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ABSTRACT

The theoretical and research literature on women in treatment has increased over the past two decades as a result of the growing concern about the appropriateness and adequacy of mental-health services for women. This annotated bibliography, in six sections, is a response to the need to survey, organize, and abstract this new body of literature. The sections, each containing detailed abstracts of articles and books from the early psychoanalytic writings to the theoretical and practical concerns of the present days, cover the following areas: (1) theoretical literature on the psychology and biology of women: (2) criticism of the treatment of women: (3) the research response to criticism: (4) modifications of therapeutic practice and new approaches: (5) treatment for specific problems and populations of women: and (6) alternative methods such as assertiveness training and self-help. (Author/CS)

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National Institute of Mental Health

Changing Directions in the Treatment of Women:

A mental health bibliography

Elyse Zukerman

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

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Preface

In the past decade there has been considerable criticism of traditional mental health services for women. The women's movement has been the primary source of this criticism as well as the impetus for changing directions in the treatment of women. Traditional mental health institutions and practitioners have been accused of sex bias, perpetuating sex-role stereotypes, and harming, rather than helping, women by guiding them to conform and to adjust to unhealthy life situations. Women—some with some without mental health training—have developed alternatives to traditional mental health approaches and services. Their efforts, in addition to their criticism, have challenged traditional theorists and psychotherapists to deal with past errors in psychological theory and to modify their therapies to be responsive to women and to promote women's development.

The theoretical and research literature focusing on women in treatment has grown as a result of this increasing concern about the appropriateness and adequacy of traditional forms of psychotherapy. In response to the need to survey, organize, and abstract this new body of literature, this bibliography was undertaken with the objective of providing a helpful resource for the research, therapy, and women's communities and for individual women consumers.

The bibliography's six sections are based on a conceptual framework that evolved quite naturally from a focal point of criticism—criticism of early psychoanalytic theories and their influence on women and criticism of traditional psychotherapy with women. The bibliography first takes a step back in time to consider the early psychoanalytic theories before moving on to current critical literature and the response it has evoked—a response that is reflected in new theory, research, and practice literature. Before the bibliography's conceptual framework and the literature abstracted in the subsequent six sections are elaborated upon, some background information is required about the criteria for the *selection of material, the actual search of the literature, and the literature of the 1960's as distinguished from that of the 1970's.*

Selection of the Literature

All the literature abstracted in this bibliography relates to the treatment of women for the period 1960 through the winter months of 1977; the one exception is the early psychoanalytic material, which does not fit this time frame but clearly influenced psychotherapy with women. Ideally, the material selected for inclusion identified a specific concern with women or included sex as a primary or secondary variable in studies of both clinical judgment and the process and outcome of treatment. At the very least, women were purposely rather than incidentally the subject. In instances in which the major focus was not on the actual treatment of women, the article was selected because it contained implications for treatment.

No claim of inclusiveness is made for this bibliography. Material was selected, however, to provide a comprehensive perspective on the treatment of women for the identified period of time. The amount of literature in a particular section generally reflects the extent of interest or effort in that area. For example, the sexuality/sexual dysfunction subsection is large; more literature was available for inclusion because this is a problem area that receives much attention. In contrast, there are only a few articles that deal with battered women and mastectomy patients; concern for women with these problems is just beginning to be expressed, and, consequently, only a few articles were available on these subjects. Regarding the placement of the literature, several articles could have been appropriately included in more than one section. Articles that dealt with the use of assertiveness training for problems relating to sexuality, for example, could have been placed in either the specific problem area section or in the section on assertiveness training; they were grouped with the latter. Other similar decisions were made. In these situations, articles are cross-referenced in the subject index.

Much of the literature included in this bibliography rejects a person-centered definition of women's problems. The factor of environmental stress is recognized, women's problems are examined in the context of their social/political situation *in our society, and new data concerning the effect of women's social situations on their mental health are considered. Consequently, treatment is broadly defined to incorporate this extended concept of the source of women's problems, and the literature selected for inclusion goes beyond psychotherapy to include all efforts that help women grow and develop, cope with the crises that women experience, and deal with the pain and problems created by their social situation in our culture.*

In order to fulfill the objective of providing a comprehensive view of women in treatment, neither quality of the material nor agreement with the content was criteria for inclusion. Similarly, identification as a "negative" article—one that revealed a subtle or blatant bias against women—was not a criterion for exclusion. In fact, some negative material was purposely included to assure awareness of the fact that women continue to be subjected to sex-role stereotyping and sexist treatment.

Although at times it was difficult not to comment, the literature is abstracted from the point of view of the authors of the individual articles/books. No criticism or comments are offered, and no evaluations are made of conclusions reached by researchers. This writer accepts responsibility and apologizes for any misrepresentation that may have occurred in the abstracting process.

Search of the Literature

Three information systems were used in the search of the literature: the National Clearinghouse for Mental Health Information, the National Library of Medicine MEDLINE, and POPINFORM, the On-Line Information Retrieval System of the Population Information Program, Science Communications Division, George Washington University. Additionally, the facilities and resources of the American Psychiatric Association Library, the National Library of Medicine, the Library of Congress, and the George Washington University Medical-Health Sciences Library were used to locate relevant material and to conduct a hand search of Psychological Abstracts *and numerous journals representing various mental health and social science disciplines for the period 1960 through the winter months of 1977. Other material-gathering* *efforts included correspondence and telephone contacts, review of the references included in the literature gathered, and examination of the following bibliographies:* Topical Bibliography on the Psychology of Women, *Helen Baer and Carolyn Sherif;* Women and Mental Health: Selected Annotated References 1970-1973, *Phyllis E. Cromwell, editor;* Women and Psychology, *prepared by the Cambridge-Goddard Graduate School for Social Change;* The Psychology of Women: A Partially Annotated Bibliography, *Joyce Jennings Walstedt; and* Anti-Psychiatry Bibliography and Resource Guide, *Kathy Frank.*

Literature of the 1960's Contrasted to Literature of the 1970's

The time frame selected for the bibliography, 1960 to early 1977, coincides with the emergence and growth of the women's movement in the United States. However, upon review of the literature, it soon became obvious that the impact of the women's movement was not reflected in the theoretical and research literature concerning the treatment of women until the 1970's.

One obvious difference between the literature of the 1960's and that of the 1970's is the actual amount of material that focused on women and their treatment. The total number of articles/books included in the bibliography for the 1960's is 33. There was clearly less material in the 1960's that had women as the subject, that identified a specific concern with women, or that dealt with the effect of the sex of the patient on the process and outcome of treatment.

Another distinction between the two groups of material is the more narrow range of concerns in the earlier literature. The material of the 1960 period directs its attention to women with problems relating to mothering, alcoholism, depression, dependency, sociopathy, phobias, and sex. Environmental stress and the effect of the social/political situation of women in our society on their mental health were not considered. Although all material in the 1970's does not view women's problems in this broader context, much of it does—enough so that there is a marked contrast between the material of the two periods. The literature of the 1970's definitely reflects the impact of the women's movement; the literature of the 1960's does not.

Bibliography Framework—Sections I-VI

Section I

Initial review of the literature revealed considerable criticism of the traditional theories concerning the psychology and biology of women as well as of traditional psychoanalytic/psychotherapeutic practice with women. Consequently, it seemed appropriate to first devote some attention to the early works themselves—to Freud and his early supporters and dissenters. Focus then moves easily on to current critical and supportive literature of these early psychoanalytic theories and their influence on women, followed by new theory and research literature. Although this first section "Theoretical Literature on the Psychology and Biology of Women" is small in terms of the number of abstracts, it is actually reasonably complete, thanks to Psychoanalysis and Women *edited by Jean Baker Miller and* Women and Analysis: Dialogues on Psychoanalytic Views of Femininity *edited by Jean Strouse. These two books provide a helpful overview; they include the works of many of the early theorists along with commentaries and new theory.*

Section II

The women's movement has been a severe critic of traditional psychotherapy and has acted as a catalyst for change. In this second section, "Criticism of the Treatment of Women," the focus is on sexism in both traditional psychotherapy and in other treatment approaches. The mostly women authors of this section identify with either or both the women's movement and the professional mental health community. The themes of the articles correspond to the four types of sexist behavior toward women clients reported by the American Psychological Association Task Force on Sex Bias and Sex-Role Stereotyping in Psychotherapeutic Practice—fostering traditional sex roles in women clients, exhibiting bias in expectations of women, sexist use of psychoanalytic theory, and responding to women as sex objects. In their discussions of the sexist nature of psychotherapy and other treatment approaches, the authors usually include recommendations for changes identified as a necessary response to the new views and attitudes created by the women's movement.

Section III

The third section is a "Research Response to Criticism." The current and strong criticism of psychotherapy practice has clearly stimulated research interest in two new issues—sex bias and sex-role stereotyping. These issues are represented in the first part of this section, "Influence of Patient's/ Therapist's Sex on Clinical Judgment."

The research response of the second and third parts of this section, "Effect of Sex of Client/Therapist on Process and Outcome of Therapy," and "Effect of Sex of Client on Process and Outcome of Various Treatment Approaches in Various Treatment Settings," reflects an increase in the research studies that examined sex differences in the process and outcome of treatment. There were a few articles in the 1960's that dealt with sex as a primary or secondary variable in studies of the process and outcome of psychotherapy and other treatment approaches. But interest in this area has grown along with concern about the claims of sex bias, sex-role stereotyping, and the damaging effect of psychotherapy on women. The second part of this section examines sex differences in the process and outcome of psychotherapy only, whereas the third part considers sex differences in the process and outcome of a number of different treatment approaches.

The fourth part of this section is research overviews. These summaries provide some idea of the current state and direction of the research in relation to the treatment of women. Although this is the only section that specifically concentrates on research, research literature is scattered throughout the bibliography.

Section IV

There can be little question that the mental health community has responded to the women's movement and its criticism. That response is the next logical progression in the bibliography's framework and the basis for this section, "Response to Criticism—Modifications of Therapy and New Approaches: Theory and Research."

Essentially the response is a positive one and has led to the modification of existing treatment and efforts to develop new approaches. One form of response has been the develop-

ment of women's groups and the deliberate use of women therapists for women clients. Some authors respond by defending the treatment approach they have been using, while many suggest and describe modifications of existing methods and new approaches to treatment.

Section V

In terms of the bibliography's framework, the fifth section, "Treatment for Specific Problems and Populations of Women," can be considered a continuation of the fourth section, for treatment modifications and new approaches are in use in these specific problems areas. Material is also included, from both the 1960's and the 1970's, which does not reflect the impetus of the women's movement, which does not view women's problems in the context of their social situations, and which uses a traditional and at times sexist treatment approach. This latter material—in terms of the framework—can be identified as a "no-response" response to current criticism.

The specific problem areas included in this section are alcohol/drug abuse, depression, marriage/divorce, motherhood/mothering, sexuality/sexual dysfunction, work-related and an "other" category. This last group contains articles on the treatment of hospitalized women, women suffering from anorexia nervosa or obesity, women with a "femininity complex" or a severe character disorder, and women who have been diagnosed as passive-dependent, sociopathic, phobic, hysterical, or paranoid.

Section VI

Finally, the criticism has brought us to the final stage of the framework—"Alternative Approaches to Traditional Psychotherapy." Women working both within and outside the mental health professions have developed alternative approaches. Some of these approaches appear as a direct development emerging from the women's movement, such as assertiveness training, consciousness raising, and feminist therapy. Crisis intervention, an approach that emerged in the 1960's, lends itself easily to the development of services that respond to the needs of women during situational crises, needs that were previously not being met. Self-help, although not a new concept (e.g., Alcoholics Anonymous), also lends itself *comfortably to the objectives of an alternative approach. These alternative approaches are the focus of this final section. The "other" category of this section includes a few alternative approaches that did not belong with any of the other approaches.*

Finally, another group of self-help material is also included in this bibliography: self-help reading for women. This section is based on the assumption that, with additional knowledge and support provided by the written word, women can at times resolve their own problems without seeking outside assistance. The section includes literature to help women become more assertive generally and in relation to their sexuality, cope with the crises of breast cancer and separation/divorce, and learn more about their bodies and sexuality, as well as guidelines for setting up consciousness-raising groups or a women's center. Guidelines are also included for the woman who decides that she does in fact want to seek the help of a therapist.

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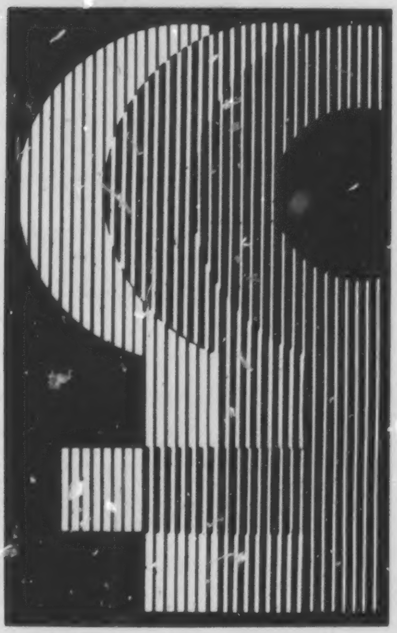
I.

THEORETICAL LITERATURE ON THE PSYCHOLOGY AND BIOLOGY OF WOMEN



Freud, Deutsch, and Early Challengers

Recent Critique/Support of Early Psychoanalytic Theories

New Theory and Research

Freud, Deutsch, and Early Challengers

1.

Adler, Alfred. Sex. In: Miller, Jean Baker, ed. *Psychoanalysis and Women: Contributions to New Theory and Therapy.* New York: Brunner Mazel, Inc., 1973. pp. 33-42. (Paperback edition: *Psychoanalysis and Women.* Baltimore, Md.: Penguin Books, Inc., 1973. pp. 40-50.)

Adler contends that all the institutions of this culture and its traditional attitudes have been determined and are maintained by males for "the glory of male domination." Even children reared by parents attempting to lead egalitarian lives will be affected by traditional attitudes. Children see the privilege of manhood from their earliest days and can sense that women do not believe in their own equality. Because masculinity dominates, boys are urged to be manly and to secure power and privilege for themselves. Girls hear and see that which robs them of any sense of their own value, destroys self-confidence, and eliminates any hope of doing something worthwhile. Consequently, it is not surprising that many of them appear to retreat from life. The advantages of being a man are clear and cause severe disturbance in the psychic development of women. Three types of women involved in fighting against the feminine role are presented. The first type of woman develops an active, or so called "masculine," role and is very energetic in striving for success. The second type of woman seems well adjusted and is obedient, humble, and resigned. By her lack of competence and helplessness, she shows the need for consideration. Her revolt takes the form of making it clear that her life is not happy. The third type believes in her inferiority and the superiority of men. She praises men, but through her clear feelings of weakness and demand for extra support she gets her revenge by placing all responsibility on the man. A case history is given of a 36-year-old woman driven mad by her inability to become reconciled to her role. Women fear menopause, because it represents the loss of what small significance they had, but a human being's worth does not end at a certain age and must be guaranteed. All of these given manifestations of illness in women are caused by the prejudice that permeates this civilization. The fallacy of man's superiority and woman's inferiority creates a tension in all erotic relationships and makes happiness in relationships between men and women nearly impossible. There must be calm education to change this. Adler contends that women's efforts to gain freedom and equality must be supported in order to ensure the happiness of all human beings.

2.

Deutsch, Helene. The psychology of women in relation to the functions of reproduction. In: Strouse, Jean, ed. *Women and Analysis: Dialogues on Psychoanalytic Views of Femininity.* New York: Grossman Publishers, 1974. pp. 147-161. (Paperback edition: New York: Dell Publishing Company, Inc., 1974. pp. 173-188.)

Deutsch explains how the change in a female's valuation of her genital organ occurs and what relation it bears to the function of reproduction in women. She discusses the difficulty the female libido has in moving from its infantile attachment to the "masculine clitoris" to the final phase of attaining a feminine attitude. It is in this final phase that the clitoris is abandoned, and there is full realization of the vagina as the organ of pleasure. Deutsch portrays the clitoris as an inadequate substitute that assumes the importance of the penis for the girl throughout her childhood.

The girl is unaware of the existence of her vagina and the task of conducting the libido from the clitoris to the vagina falls to the penis. The author presents a very involved construct to describe the experience of coitus for a woman. She sees the woman as simultaneously playing the roles of mother and child during coitus, and this relation continues in pregnancy. The vagina is a sucking organ and represents the child. If the woman gives up the claim of the clitoris to represent the penis, her vagina becomes a second ego as the penis is for the man, and she has "reached the goal of feminine development." In women, reproduction has two phases, orgasm and parturition, its termination. Deutsch contends that coitus acquires a pleasurable character mainly because it constitutes an attempt at, and the beginning of, parturition. Parturition is "an orgy of masochistic pleasure" and the termination of the sexual act, analogous to introjection in men. The interval between coitus and parturition, pregnancy, is filled with complicated processes. According to Deutsch, all the phases of libidinal development occur during the course of pregnancy as the mother's relation to the child changes. She explains that the man measures and controls his ego-ideal by his productions in the outside world through sublimation. The woman directs all her tendencies toward sublimation, which the man uses in intellectual and social activity, toward the child who represents her sublimation product. Deutsch distinguishes two types of women according to their mental reaction to pregnancy and explains the causes of their reaction by describing their libidinous relationships to the fetus. The harmony inaugurated with impregnation is seen as soon disturbed by ambivalence toward the child, and parturition can be viewed as the result of a long struggle. After birth, the child continues to represent the mother's unattained ideals and Deutsch views this as the path women must take from narcissism to full object-love. In lactation the bliss of the primal stage of pregnancy, where subjects and objects are one, is reestablished. Deutsch describes it as a repetition of coitus where the penis represented the breast. Deutsch concludes by noting how perfect the reproductive process is in repeating the development of the libido and in working out sublimation in relation to the child. She asserts that were it not for the masculine strivings of the clitoris, women would have a very simple time finding their way to a mastery of existence.

3.

Freud, Sigmund. Female sexuality. In: Strouse, Jean, ed. *Women and Analysis: Dialogues on Psychoanalytic Views of Femininity.* New York: Grossman Publishers, 1974. pp. 39-56. (Paperback edition: New York: Dell Publishing Company, Inc., 1974. pp. 53-72.)

Freud's observations of women with strong attachments to their fathers form the basis of this report on female sexuality. He notes that the female's sexual development is complicated by the need to transfer her affection from her mother to her father and give up her primary sexual focus, the clitoris, for the vagina. Freud reports finding two unexpected facts about the women he observed. The first was that women with an intense attachment to their fathers had previously experienced a period of equally intense attachment to their mothers. The second fact was the duration of this maternal attachment which was longer lasting than he had expected in several women, sometimes continuing into the fourth or even fifth year of life. Thus, the pre-Oedipal phase in women is far more important than previously thought and has within it room for all the fixations and repressions that create later neuroses. The sources of hysteria and paranoia may also be found in this phase. Besides having to switch her sexual focus from her clitoris (a masculine phase) to her vagina (the feminine phase), the female must also change the object of her love from her mother to her father. Freud feels that this transition requires investigation. The female child acknowledges her castration and her inferiority to the male, but she also rebels against them. From this divided attitude three possible lines of development emerge. The first route leads to a general revulsion from sexuality because of dissatisfaction with the clitoris. In the second line of development, the female clings with great self-assertiveness to her threatened masculinity and becoming a man is her life's aim—this may lead to homosexuality. The third line of development is circuitous, but the only one that leads to normality. The father must be taken as the object of the Oedipus complex, which is created, rather than destroyed, by the castration complex. The reasons for the female child's turning away from the mother are numerous. She may be jealous of the mother's contact with others, or she may be resentful of the mother's strictures against clitoral masturbation. Also, the child's discovery that no women possess penises may depreciate her mother, and, additionally, she may be reproachful because she considers her mother responsible for her being without a penis. The turning away from the relationship with mother and its oral, sadistic, and phallic sexuality is also a turning from active to passive sexuality. In the end of the article Freud cites other psychoanalytic writings that deal with female sexuality in a similar vein and refutes Karen Horney's and Ernest Jones' downplaying of penis-envy.

4.

Freud, Sigmund. Femininity. In: Strouse, Jean, ed. *Women and Analysis: Dialogues on Psychoanalytic Views of Femininity.* New York: Grossman Publishers, 1974. pp. 73-94. (Paperback edition: New York: Dell Publishing Company, Inc., 1974. pp. 91-115.)

In this lecture delivered to lay persons, Freud describes the nature of femininity in psychoanalytic terms, explaining that psychoanalysis attempts to define the nature of a woman's developmental process. The study of women's sexual development was approached with two expectations that, Freud states, proved valid. The first was that the female constitution would not adapt itself to the feminine function without a struggle, and the second was that all turning points in development were prepared for or completed before puberty. According to Freud, girls and boys differ in their instincts as well as their anatomy. Girls are described as less self-sufficient and aggressive, more pliant, and having a greater need for affection. The development of a girl into a "normal" woman is considered a more difficult process than that of a boy into a man. The girl must accomplish two tasks that have no parallel in male development. She needs to change the focus of her sexual pleasure from her clitoris to her vagina, and she must change her original love object, her mother, to her father. The question Freud then deals with is how these two changes are accomplished. He notes that analysts have found that the girl's Oedipal relationship to her father is preceded by an equally intense relationship to her mother. This earlier relationship appears to be the decisive one during which fixations and complexes are established. The girl's strong tie to her mother is broken by penis-envy, the castration complex, or both. She considers her mother responsible for her lack of a penis. Freud explains that the same castration complex that ends the Oedipal stage of the boy causes the girl to begin her Oedipal attachment to her father. He regards penis envy as very important in the setting of life patterns; girls are believed not to develop as strong a superego as boys because their Oedipal phase is not ended sharply from fear of castration, but is only relinquished much later and perhaps incompletely. Freud indicates that the girl's discovery of her apparent castration may lead to one of three lines of development. Due to her dismay at the inadequacy of her clitoris, formerly the source of masturbatory pleasure, she may suppress her sexuality almost entirely. Alternatively, she may refuse to accept the fact of her castration and rebelliously exaggerate her masculinity; by having a constitution more suited to activity, she may develop a masculinity complex. The third possible route, described as normal feminine development, is the one in which the desire for a penis is transferred to the wish to bear a child. Indicating that feminine development is exposed to disturbance by "residual phenomena" from the early masculine phase of development, Freud suggests that this bisexuality may account for what has been regarded as the enigma of women. Freud additionally lists some psychical peculiarities of the mature female, such as narcissism and shame, little sense of justice, less ability than man to sublimate her instincts, and unlimited satisfaction only from the birth of a male child. Freud acknowledges that this view of femininity is incomplete, because it describes women only so far as their nature is determined by their sexual function.

5.

Freud, Sigmund. Some psychical consequences of the anatomical distinction between the sexes. In: Strouse, Jean, ed. *Women and Analysis: Dialogues on Psychoanalytic Views of Femininity*. New York: Grossman Publishers, 1974. pp. 17-26. (Paperback edition: New York: Dell Publishing Company, Inc., 1974. pp. 27-38.)

Although Freud identifies the data he presented in this paper as highly theoretical, he deemed them important to the creation of a better understanding of the early sexual development of women—an understanding vital to effective psychoanalysis. Freud writes that previously focus has been on boys and their early development. The Oedipus complex, which is developed at the time of suckling and is dispelled by the fear of castration and narcissistic focusing on the genitals, has been well worked out. In girls the Oedipus complex is not so simple. The girl's primary focus is also the mother, but it changes to the father. To explain this shift, Freud suggests that the girl early discovers her lack of a penis and wants one, for she recognizes its superiority to her own sexual organ. Penis-envy sets in, and, if this envy cannot be resolved, development toward femininity will be thwarted. Penis-envy exists in later life in the form of jealousy which plays a larger part in the lives of women than men. Penis-envy also loosens the relationship to the mother, whom the girl considers responsible for her lack of a penis, and humiliation over the inferiority of the clitoris creates an intense feeling against clitoral masturbation. Freud believes this is vital in forcing girls away from masculine masturbatory activity and onto the path of feminity. The girl replaces her unfulfilled wish for a penis with the desire for a child and, for this reason, turns her affection to her father. Thus, the Oedipus complex in the female is a secondary formation preceded by the castration complex. In boys the Oedipus complex is destroyed by the terror of castration. In girls there is no real motive for it to end. The Oedipal attachment is merely slowly abandoned or repressed, although in some cases it persists. The super-ego is not so impersonal as it is with males, and Freud hesitantly suggests that this may be why women show less sense of justice than men and are apt to be ruled by their feelings.

6.

Horney, Karen. The flight from womanhood: The masculinity complex in women as viewed by men and women. In: Miller, Jean Baker, ed. *Psychoanalysis and Women: Contributions to New Theory and Therapy.* New York: Brunner Mazel, Inc., 1973. pp 3-16. (Paperback edition: *Psychoanalysis and Women.* Baltimore Md.: Penguin Books, Inc., 1973. pp. 5-20.)

The analytical research of psychoanalysis has been one-sided, focusing only on the minds of boys and men, according to Horney. She considers this no surprise, since psychoanalysis was created by a man and men have developed its original ideas. Not denying the existence of penis-envy, Horney reinterprets it in terms of social factors as well as biological relations. She suggests that the psychoanalytic concept of penis-envy may contribute little toward increasing understanding of women's development and offers the perspective of the philosopher George Simmel as possibly being more explanatory. Simmel points out that this entire civilization is masculine. The State, its laws, morals, and religion are all the creation of men, and because of this basic reality the standards used to judge values of male and female natures are entirely masculine. Inadequate achievements are labeled "feminine," and distinguished achievements by women are called "masculine." Heretofore, the psychology of women has only been dealt with from the point of view of men. This is not objective but colored by men's subjective, affective relations with women. Having adapted themselves to the dominance of men's wishes, women believe these psychoanalytic interpretations to be their "true nature." Horney presents female development as paralleling that of men and gives the example of penis-envy as being entirely from the viewpoint of how a boy would view a girl. If one's thoughts can be freed from the masculine mode, a whole new perspective emerges. Nothing has been said of motherhood, of bearing life within oneself and the joys of nurturing a child. Horney maintains that from a biological point of view women have, in motherhood, a physiological superiority. Boys have an intense envy of motherhood. It may be that men depreciate childbearing and create the concept of penis-envy because of their own envy. The need of men to compensate for their minor role in the creation of human beings may lead to their greater cultural creativity and need for achievement. There seems to be no corresponding impulse in women to compensate for their lack of a penis. In discussing flight from womanhood, Horney asserts that the Oedipus complex in women leads to a regression to penis-envy, with girls renouncing the father as a sexual object and simultaneously recoiling from the feminine role. The facts relating to early infantile onanism, the physical expression of the excitations due to the Oedipus complex, are discussed as central to achieving an understanding of this flight from womanhood. Horney suggests that flight from femininity, or the masculinity complex, results from the interaction of psychic and social factors. It may come from the woman's unconscious desire to avoid realizing libidinal wishes and fantasies about her father. The unconscious motives for the flight from womanhood are to some degree reinforced by the actual social subordination of women.

7.

Moulton, Ruth. Early papers on women: Horney to Thompson. *The American Journal of Psychoanalysis*, 35(3):207-223, 1975.

This article reviews Karen Horney's contributions to the psychology of women, attempts to explain why she alone was able to make such contributions at that time and place, and traces the transition from Horney's early work to the new studies of women begun in America in the 1950's by such pioneers as Clara Thompson. A brief review is given of the accepted theories about women at the time Horney began to write. Except for their role in reproduction, women were perceived as biologically determined inferior human beings. The author notes that only after Horney's first paper "The Genesis of the Castration Complex in Women" in 1922, with its conflicting view of female sexuality, did Freud begin to deal specifically with the subject of women's sexuality. A history of Horney's psychoanalytic background, her studies first with Abraham and then the more enlightened Sachs in Berlin, and her personal family life is provided as background to her rebellion against Freudian concepts. The fact that Horney reared three daughters and had a chance to observe normal female development is seen as vital to her disavowal of traditional feminine theory. Moulton discusses Horney's objections to the use of male standards to measure female behavior and to the idea that woman's true nature is to adopt the wishes of man. She also focuses on (1) Horney's work on penis-envy and suggestion that motherhood created envy in boys; (2) her work on frigidity, which emphasizes the patient's rejection of the female role, incapacity for a full love relationship, and lack of faith in woman's capacity for real achievement; and (3) her theory on the "masculinity complex." Other analysts of this period whose work coincided with Horney's are mentioned (Muller, Muller-Braunschweig, Jones, Klein, DeGroot), and their various theories are briefly discussed. In the tracing of attitudes toward women that differed from Freud's, Ferenczi is identified as particularly important since he was Clara Thompson's analyst. World War II forced most of the European analysts to migrate to America, and it was in the less tradition-bound approach of this country that cultural factors came to be emphasized over constitutional ones. Harry Stack Sullivan, Clara Thompson, Karen Horney, and Erich Fromm are presented as the leaders of the so-called cultural school, and their influences on one another are discussed. Additionally, some of Horney's new ideas on female sexuality that evolved in the cultural school are presented. After a brief review of Clara Thompson's life and career as well as her contact with Horney, a summary is provided of some of Thompson's major writings. Moulton notes that Thompson's pragmatic work was based on clinical observations within a social milieu. She was particularly interested in how women dealt with the increasing awareness of their cultural inferiority. Stressing the significance of cultural factors, Thompson commented directly on some of Freud's theory—she viewed penis-envy as the symbolic expression of women's desire for equality with men. It was her belief that the basic nature of women is still unknown. Moulton concludes that the present rash of activity describing differences between the sexes may provide data that will more clearly identify the influences of culture, constitution, and early family experience in the formation of a person.

8.

Symonds, Alexandra. Discussion of "Early Papers on Women: Horney to Thompson." ***The American Journal of Psychoanalysis,*** **35(3):225-229, 1975.**

In her response to Ruth Moulton's "Early Papers on Women: Horney to Thompson," Symonds notes that the new wave of feminism has brought about a reexamination of all former conclusions about men and women. Psychoanalytic theory is being read with new eyes, and hidden treasures are being uncovered. She points out that Horney's work on women lay dormant for 40 years and Thompson's for 30. Symonds believes that Moulton's paper adds an important dimension to psychoanalytic understanding by providing a context and background for the work of these two women. The paper also illustrates how women like Horney and Thompson were ahead of their time in being unafraid to strike out on their own on the basis of personal integrity. Symonds praises Moulton's paper for ably tracing Horney's progression from the rigidity of Freudian theory to a more holistic, humanistic approach and for identifying the importance of Thompson's contribution. Symonds expresses surprise that Freud's attitudes toward women are still accepted, even in the face of greater familiarity with the works of individuals like Horney and Thompson. She believes, however, that there are signs of change and that even Freudian psychoanalysts are reconsidering their theories about women. Symonds concludes with the observation that truth is not enough to produce change—there must also be a readiness. In years past, this work on women, however valid, was still too disturbing to be generally accepted.

9.

Thompson, Clara M. Biologic aspects. In: Green, Maurice R., ed. *On Women*. New York: The New American Library, Inc., 1971. pp. 17-30.

This chapter presents the biologic facts that distinguish women from men and that must be dealt with in any appraisal of woman's role in society. Thompson writes that all societies recognize certain physiologic activities as belonging only to the female, although the attitudes toward these activities may vary from culture to culture. Hormonal differences may influence how members of the two sexes cope with their lives, but the influences of society and personal experiences clearly are vital. Sexual interest is also seen as influenced more by these factors that by biology. Based on her own observations, Thompson questions Freud's assumptions that the female does not discover her vagina until puberty. She also reports on research on the importance of the clitoris for female orgasm and asserts that in the human female there are two areas where the peak of sexual excitement is experienced. The varying importance of the vagina and clitoris from woman to woman is recognized as due more to conditioning than biology. Although woman's sexual drive reveals more periodicity than man's, it is no less insistent. Puberty brings on the first exclusively female activity, menstruation. Thompson indicates that findings about the emotional and sexual effects of the woman's monthly hormonal cycle are not universally true and that psychogenic factors alter them. Menstruation clearly plays both a psychological and physiological role in every woman's life, and society strongly influences her attitude toward it. Pregnancy is also discussed as a factor in all women's lives, with attitudes toward it again strongly influenced by culture. Additionally, labor and lactation are discussed in terms of psychogenic influences. Thompson suggests that the care of young children, which is generally the responsibility of the mother, may prove far more disruptive to her being than pregnancy. Focusing on menopause as another biological difference between men and women, Thompson notes that for women in this society the greatest hazards of menopause are culturally induced. The work of Ford and Beach on biologically determined sex differences in animals is cited throughout, but the author suggests that in humans there are other factors as important as biology. In conclusion Thompson states that biologically attributed differences in the achievements of men and women are not supported by cross-cultural evidence.

10.

Thompson, Clara M. Cultural pressures in the psychology of women. In: Green, Maurice R., ed. *On Women.* New York: The New American Library, Inc., 1971. pp. 125-141.

In this article Thompson begins her discussion by noting that cultural influences are becoming more significant in psychoanalytic work. Although culturally produced neurotic trends work on both sexes, women are identified as having different problems because of their biologic functions and, more importantly, because of the cultural attitude toward women. Freud's biologically based theory of female development is reviewed and, based on Thompson's clinical experience, is considered to provide a less than accurate picture. The principal sources of error in Freud's interpretation are identified as follows: He observed entirely from a masculine point of view, and, although he only studied women in his own culture, he interpreted what he saw as applying universally. Thompson asserts that the "biologic woman" cannot be separated from the total cultural picture. She suggests that a woman who is "biologically fulfilled" will not envy man's biology. In the United States where a woman's biologic makeup functions as a handicap, her drives are often denied expression, and fulfillment of the woman's role puts her at a disadvantage. Although changes are occurring, there are still restrictions placed on women that work to men's advantage. With this in mind, Thompson examines the particular cultural pressures that produced the women Freud observed. Freud identified penis envy as the problem central to neurosis in women, and Thompson notes that, if penis envy is viewed symbolically, women certainly had much reason to envy the advantages possession of a penis gave men. At puberty girls were severely restricted in their behavior and taught to deny needs and desires. Freud considered the struggle against this restriction as a natural event in the process of accepting the biologically normal feminine role. It is clear to Thompson that woman's passivity is the result of social pressures and that the characteristics Freud regarded as inherently feminine derive from the dependent role women play in the culture. Comparing the modern woman with the woman of Freud's era, Thompson asserts that, although woman's position has greatly changed, the culture is still in a state of transition. Victorian attitudes persist in the psychology of most women. Penis envy remains symbolically valid because women continue to have reason to envy man his greater freedom and the personal characteristics this freedom fosters. Freud's three solutions for women in dealing with their envy of men are presented, and the role cultural influences play in them is discussed. Thompson suggests that present-day culture invites masculine behavior in women; she distinguishes between this culturally induced masculine behavior and behavior that indicates a "masculinity complex." According to Thompson, psychoanalysis is only familiar with the psychology of women in one type of culture. The characteristics Freud observed to be flowing from woman's biologic nature can now be recognized as flowing from woman's situation in Western culture. Thompson concludes with the comment, "the basic nature of woman is still unknown."

11.

Thompson, Clara M. In: Green, Maurice R., ed. *On Women*. New York: The New American Library, Inc., 1971. pp. 192.

The 13 chapters of this collection of Clara M. Thompson's writings on women were drawn largely from an incomplete book of hers on the psychology of women, with some portions selected from the previously published *Interpersonal Psychoanalysis: The Selected Papers of Clara M. Thompson*. In the first chapter, "Biologic Aspects,"*Thompson focuses on the concept that environment and experiences are as important as biology in determining who women will be and how they will act. She discusses the necessity of cross-cultural data to demonstrate that differences between men and women are biologically determined. Thompson gives Freud credit for his contributions and observations but critizes his conclusions, which she regards as the product of cultural attitudes. For example, she attributes women's seeming lack of character in echoing the convictions of the men they love not to an unclear ending to the Oedipal phase but, rather, to women's inferior position in society. Because women are dependent, they must try to make themselves agreeable to those in control. Thompson asserts that women's psychology is something in its own right and not just a negation of maleness. In the chapter, "Penis Envy,"* Thompson claims that Freud's concept of penis-envy is not needed to explain women's feelings of inferiority and envy, for these feelings are created by the social reality in which women live. Women, like any other underprivileged group in a competitive society, have a valid basis for their envy of men because of the limitations society places on female independence and development. She concludes that penis-envy does not describe a clinical entity developing from a constant source, as Freud claims, but can be viewed as a symbol and rationalization for women's various feelings of inadequacy stemming from their environment. In "Relations With Her Own Sex," Thompson chronicles women's intimate relationships with each other and notes that the capacity for genuinely liking one's own sex is vital for healthy relationships in general. Thompson writes in 1941 in "Role of Women in This Culture," that although women are freer than before, discrimination still exists. She explains that women, who are now living in a period of transition and conflict created by new opportunities outside the home, are without either training or precedent to prepare them for a life in which marriage is not the only goal. Thompson asserts in "Cultural Pressures in the Psychology of Women"* that neuroses are culturally produced. She again criticizes Freud's theories of women—he worked entirely from a male point of view, perceived women as biologically inferior rather than just different, and drew universal conclusions about the nature of women from observations made only on women of his own time and class. She concludes that "the basic nature of woman is still unknown." In "Some Effects of the Derogatory Attitude Toward Female Sexuality," Thompson continues to deal with the influence of culture on the individual and makes the point that women must accept their own sexuality and learn to express it. She again addresses the conflicts of women in "Working Women." Women are educated with the sa[illegible] standards of success as men, but with expectations of marriage and having children, and, yet, they receive no tangible payoff for success as wives and mothers. Most women find themselves unhappy when confined to either home or work. As women are different, not inferior, a woman will not find satisfaction until she finds her own standard for achievement rather than a masculine one. In the final chapter, Thompson discusses middle age as a period of biological equilibrium. She feels that menopause need not be a cause of great discomfort, while recognizing that there is some physical instability and that for some women it may bring the awareness of an unlived life. According to Thompson, a fulfilled early life leads to a productive middle age with both professional and emotional rewards. Three of the book's 13 chapters are devoted to a discussion of childhood, adolescence, and psychopathology of adolescence. A brief biography of Clara Thompson concludes the book.

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*Abstract of articles included in this bibliography.

12.

Thompson, Clara M. Penis envy. In: Green, Maurice R., ed. *On Women.* New York: The New American Library, Inc., 1971. pp. 73-78.

This chapter deals with the modern meaning of penis-envy, which is presented as a symbolic representation of the present attitude of women as opposed to Freud's original definition of the term. Thompson asserts that a struggle exists between the two sexes in this competitive culture that is no different from the struggle between any two combatants in which one has definite advantages in prestige and position. Sex is emphasized in this struggle only because of the symbolic function of the sex organs, and because sexual differences are obvious and convenient marks of derogation in competitive situations. The penis is the sign of those in power, and penis-envy in women is similar to the attitude of any minority group toward the dominant group in a competitive culture. Contending that envy is characteristic of a competitive culture, Thompson describes different ways in which character can develop to cope with this feeling. The clinical picture of penis-envy is one in which the woman is hostile. She envies a weapon that man can use to dominate and destroy her, but Thompson points out that this attitude need not have a specific relationship to the sexual life or the genitals as such. Relationships between men and women are marked by two special features—the attitude of a minority group to a dominant group and the fact that the sexual act, the most intimate form of interaction, occurs within this relationship. Thompson notes that industrialization contributed to women's feelings of inferiority and envy by diminishing the importance of the traditional family and the role of women within it. The two factors in the culture identified as most important to a discussion of penis-envy are its general competitiveness and its tendency to place an inferior evaluation on women. Thompson concludes that in the clinical view penis-envy has only a secondary relationship with sexual life and instead involved in all aspects of living. If women's feelings of inferiority are not attributed to a biologic lack (as Freud viewed them), penis-envy no longer describes a clinical entity with a constant origin; rather, it is a symbol and rationalization for feelings of inadequacy in women. The reality of women's underprivileged status gives an impression of validity to the rationalization.

Recent Critique/Support of Early Psychoanalytic Theories

13.

Gilman, Richard. The femlib case against Sigmund Freud. *The New York Times Magazine*, Jan. 31, 1971. pp. 40-42, 46-47.

In this article, Gilman recounts his initial difficulty in understanding the violent response of feminists toward Freud and Freud's theories. After reading the feminist critiques and reviewing Freud's work, however, he came to agree with the feminist position that Freud maintained a radical bias against women which forms an essential part of psychoanalysis. Gilman sees the core of the feminist complaint against Freudianism in the concept "anatomy is destiny." Psychoanalysis has built the anatomical and biological differences between men and women into a value system that physiology itself does not ordain. Physical differences do not mean that existing sex roles are inevitable. Gilman points out that the most striking sexism in Freud's writings is the fact that his entire theory of sexuality is based on a masculine model, with feminity as the incomplete or deficient aspect of this model. Freud's belief in the biological superiority of the penis, which forms the basis of his sexual theory, is criticized on the grounds that the dominance of the penis was conferred by society and not by biology. Other aspects of Freudian theory are shown to be entirely male dominated and based on Freud's acceptance of man's superior position in his specific culture as being universal and "natural." Criticisms of Freud's denigration of the female sex organs are also presented. In addition to their constitutional handicaps, women were also viewed by Freud as suffering from "psychic disabilities, moral afflictions and existential disqualifications." Although Freud's theories are felt to have gone largely unchallenged by other psychoanalysts, Gilman notes a growing recognition that women were Freud's blind spot. It is suggested, however, that Freudianism is being used as a defense by those who feel threatened by the women's liberation movement. Reference is made to Simone de

Beauvoir, who saw man's exploitation of women as at least in part a rationalization for largely unacknowledged feelings of resentment and fear. Feminist anger against Freud is viewed as stemming from his reinforcement of biological determinism at the very point in history when technology was becoming capable of eliminating it. Gilman concludes with a quote from John Stuart Mill to the effect that only an imperfect and superficial view of women can be obtained until women tell their own story—and this is what the feminists are now beginning to do.

14.

Koedt, Anne. The myth of the vaginal orgasm. In: Agel, Jerome, ed. *The Radical Therapist.* New York: Ballantine, 1971. pp. 127-137.

Koedt begins by establishing the clitoris as the core of female sexuality; she states that the vagina is neither sensitive nor constructed to achieve orgasm. The myth of the vaginal orgasm, with its false anatomical assumptions, is identified as responsible for having inflated the rate of female "frigidity." A preference for clitoral stimulation is viewed by Freudians as a rejection of femininity, and Koedt points out that the women who blame themselves for their inability to respond "correctly" have been caused great damage by this myth. Koedt asserts that the sexual sensitivity of the clitoris and insensitivity of the vagina have always been recognized but never popularized because society is male oriented. Anatomical evidence is given, showing that the clitoris functions only as a source of sexual pleasure and that the vagina has many other functions but is very insensitive. Women who claim to have vaginal orgasms are regarded as confused by their inability to locate the source of their orgasm and their desire to fit into the male-defined view of sexual normality. Koedt lists six reasons why men have perpetuated the myth of the vaginal orgasm based on their own pleasure, needs for control, and domination of women.

15.

Janeway, Elizabeth. On "female sexuality." In: Strouse, Jean, ed. *Woman and Analysis: Dialogues on Psychoanalytic Views of Femininity.* New York: Grossman Publishers, 1974. pp. 57-70. (Paperback edition: New York: Dell Publishing Company, Inc., 1974. pp. 73-88.)

This discussion of Freud's paper "Female Sexuality" calls attention to its ambiguities and inaccuracies. Janeway's purpose is to show how these errors reveal points of strain in Freud's conceptual structure that reflect the society in which he lived. Questions of Freud's motivation and emotive personal relationships are raised not to discredit him but to put his enormous achievements into perspective. Noting Freud's inaccurate and repeated reference to "the fact of castration" in the female, Janeway suggests that Freud meant the concepts of penis-envy and the castration complex to be understood symbolically, and he used these false phrases to call attention to their latent meaning. By insisting on a bogus deprivation, Freud might actually have been pointing out the real societal deprivation of women that was then especially great. In his writings Freud succinctly and accurately described the great difficulties of adjusting to the female role. It was Freud's clinical work that evoked his conclusions about the girl's rejection of her mother when she realizes that they are alike and that they are both inferior beings. The case of Dora, which Freud did not find unusual, is dealt with in some detail to show what it reveals about the anonymity and impotence of women. Social context slips into Freud's theory by the back door, according to Janeway, but if his illuminations and discoveries are to be taken seriously, the idea of penis-envy must be viewed symbolically. Freud's personal social situation as a Jew in Vienna may have contributed to his hesitancy to create trouble about the role of women, despite the fact that he noted women's difficulties many times. In rejecting his overt awareness of social context and political urgencies, Freud cut himself off from a mode of thinking that could have added depth to his theories. Quoting Freud's description of the injurious effect of the female marriage role, Janeway comments that it is a clear description of how a particular social milieu tends to create neurosis. She suggests that the ambivalence of Freud's theories on female sexuality may have been due, at least in part, to trying to justify a real historical situation that he could not challenge in any useful way. Freud's own life reveals that he was not the kind of man to challenge the existing social structure, even as it kept him an inferior. Clearly, Freud believed women were particularly disposed to neurosis, and in "Female Sexuality" he attributed this to the circuitous route they must take to reach normal maturity. On the basis of his earlier writings, however, Janeway suggests that Freud was aware of the social element molding women's lives. She speculates that Freud's symbology and theory could suggest that, because of the importance of the pre-Oedipal attachment, as the mother's position in the world changes, so will her relationship with her daughter and its effect on the daughter's later life.

16.

Manalis, Sylvia A. The psychoanalytic concept of feminine passivity: A comparative study of psychoanalytic and feminist views. *Comprehensive Psychiatry*, 17(1):241-247, 1976.

Manalis examines the psychoanalytic concept of feminine passivity as developed by Freud and reviews the challenges to this concept from feminists and other psychoanalysts. The concepts of penis-envy and the inadequacy of the clitoris are seen as vital to Freud's view of female passivity. In this view, the girl, who is disappointed with her clitoris in comparison with the boy's penis, partially represses her sexual impulses and becomes passive. The work of Lample-DeGroot and Deutsch in support of Freud's theories of female passivity is also discussed, and it is noted that Deutsch delineated the areas of female activity as well as passivity. The feminist views of Simone de Beauvoir, Betty Freidan, Kate Millett, Shulamith Firestone, and Germaine Greer concerning feminine passivity are briefly discussed. Manalis identifies three valid points raised by these feminists: (1) Passivity has more cultural derivatives than Freud acknowledged; (2) Freud's view of girls gives the impression of the girl as inadequate, defective, and of less value than the boy; and (3) female sexual impulses should not be perceived as passive in terms of their reproductive or pleasurable functions. Citing the psychoanalytic views on feminine passivity of Horney, Thompson, Sherfey, Barnett, and Stoller, Manalis contends that these views bring Freud to task on three issues. They suggest that a woman's lack of self-esteem and sense of inferiority may be due in large part to a culture that values men more than women; that Freud's theory of the clitoris as inadequate and immature may be invalid as suggested by recent research on female sexuality; and that Freud's view of the girl's heterosexual development and desire to have a baby as secondary to her sense of being anatomically defective is questionable. Manalis suggests that the feminists are disturbed by the absence of theory as to what in a girl's development makes her feel positive and unique. Recognizing the need to explain a girl's development on the basis of what is intrinsically unique in the female, Manalis concludes that this theory can be developed more fully if a closer look is taken at the girl's identity with her mother and parental attitudes toward her as a female child.

17.

Mead, Margaret. On Freud's view of female psychology. In: Strouse, Jean, ed. *Women and Analysis: Dialogues on Psychoanalytic Views of Femininity.* New York: Grossman Publishers, 1974. pp. 95-106. (Paperback edition: New York: Dell Publishing Company, Inc., 1974. pp. 116-128.)

Mead presents some of the defense of Freud she had planned to write based on her memory of his work, and then recounts her deep shock upon rereading his essay "Femininity." Mead now identifies Freud's ideas on women as a naive expression of attitudes that are still prevalent and that the militant feminists are actually battling today. Freud asserted that the difficulty females experience in development and their failure to reach the moral heights of males derive solely from the discovery that they lack a penis and the consequently circuitous path they must take to sexual normality. He completely ignored what Mead identifies as the basis of psychoanalytic understanding—the importance of the child's experience of her/his body in all its manifestations. After expressing regrets for Freud's naive position, Mead goes on to present a cross-cultural application of his real and great discoveries about pregenital behavior and what they suggest about the importance of a child's early experience of anatomical sex differences. She maintains that in primitive societies where everything is in the open, neither sex envies the other. However, in all known cultures, male activity is always valued more than that same activity when done by women. When activities become more important, they are taken over by men as in the change from midwife to obstetrician. Historically, as long as women had the responsibility for child care and men for maintenance of the household, all girls were educated to be wives and mothers and most boys to be husbands and fathers. A historical interpretation of how the agricultural, industrial, and, finally, the medical revolution changed this system is given. Mead indicates that in Freud's time some women were responding to revolutionary changes and asking to be treated as persons independent of their roles as wife and mother. To Freud the great effort requires to break with tradition appeared to be a tremendous drive to be masculine. Mead notes that throughout this time of "masculine protest" by women, there appeared periodic social movements that emphasized the need for maternity and the extention of maternal functions into society. She feels that we are in a time when many changes are in store, and the stage is now set for a new attempt by men and women to reevaluate all of society's proscribed roles and institutions and to reexamine whether there are some ways in which Freud's insistence that anatomy is destiny may prove true. Acknowledging the fact that throughout previous history male and female roles have reflected practical conditions, she points out and discusses the many questions that have yet to be answered. Mead feels that the concept of anatomy as destiny may prove valuable if we are to keep from taking a path that may destroy all those things human beings find necessary. Mead concludes that although Freud was completely culture-bound in his discussion of women, the path he outlined still suggests that the rhythms of human development are ignored at our own risk.

18.

Menaker, Esther. The therapy of women in the light of psychoanalytic theory and the emergence of a new view. In: Franks, Violet, and Burtle, Vasanti, eds. *Women in Therapy: New Psychotherapies for a Changing Society*. New York: Brunner/Mazel, Inc., 1974. pp. 230-246.

Menaker discusses the relative nature of all psychological theory, noting that early psychoanalytic theory is limited by its failure to acknowledge the role social background plays in psychology. Freud's concepts concerning the growth and development of the male personality are reviewed, and are said to have formed the basis of his theory of feminine psychology. Menaker contends that Freud did observe penis-envy in his women patients, because women were living thwarted lives in a world dominated by men. Freud's theories on female sexuality emerged from his work with a specific population in a specific time and place, but his failure to understand the relativity of his conclusions made for a one-sided theory of the psychosexual development of women. The need to actualize to one's fullest psycho-biologic destiny is presented as basic to both men and women. This need, however, is fulfilled within a social context that defines and delimits it in terms of roles. In a time of social change, like the present, changes in roles and imagery make it clear that feminine psychology cannot be defined in terms of outer behavior. Neither can self-definition be defined by the carrying out of a role. People often seek inner security by trying to match their self-image to a social stereotype. In times of change, when this stereotype loses its unity, people who seek security in this way find themselves in conflict. Women are more vulnerable to such conflict than men, according to

Menaker, because they have been discriminated against and their self-definition is still clearly evolving. Women often seek psychotherapeutic help to resolve this conflict. A detailed case history of a young married woman is provided to illustrate modern woman's dilemma. The case points out the personal origins and effects of psychic conflict centering around the female role and the continuum between social and psychological causative factors. Menaker suggests that a woman's conflict cannot be resolved merely by assuming roles society values more than the domestic one. Self-definition, or ego, depends upon inner growth, not just the assuming of new roles. Factors necessary to inner growth that can be aided by psychoanalysis are presented. Menaker indicates that women have special problems, because they internalize their mothers' socially inherited attitudes about the inferiority of women. She briefly discusses sex in relation to feminine psychology and warns therapists against the judgmental use of norms and rigid adherence to psychoanalytic theory without regard to social reality. The author concludes that woman is evolving to new levels of ego autonomy and integration, and the task of psychotherapy is to bring all its understanding to bear in facilitating this evolutionary process.

19.

Mitchell, Juliet. On Freud and the distinction between the sexes. In: Strouse, Jean, ed. ***Women and Analysis: Dialogues on Psychoanalytic Views of Femininity.*** **New York: Grossman Publishers, 1974. pp. 27-36. (Paperback edition: New York: Dell Publishing Company, Inc., 1974. pp. 39-50)**

In this article Mitchell identifies Freud's 1925 essay "Some Psychical Consequences of the Anatomical Distinction Between the Sexes" as a key to understanding the oppression of women in a patriarchal society. She points out that it was in this essay that Freud abandoned the concept of a parallel sexual development for males and females. He began to view female psychology and female sexuality as new areas for exploration, consolidating for the first time observations about women. According to Mitchell, the essay deals with two distinct but related themes—the nature of female sexuality on which Freud really broke no new ground and the more general question of female psychology as it can be deduced from socio sexual relationships. She contends that the issue of female sexuality is dependent on the second issue. Freud believed that at infancy both sexes share the same "masculine" sexuality and that only through a series of repressions is femininity acquired. This rejects the idea that psychology corresponds exactly to biology. Mitchell asserts that detractors have overlooked Freud's idea that psychology must reflect social as well as biological background. Since the sexes are treated differently, their development must necessarily differ. Mitchell considers Freud's psychoanalytic theories to be about sexism, since they were formed within the patriarchal society that he was revealing and analyzing in his work. She feels that Freud's use of the term "femininity" as representing a negative concept helps one to understand the oppression of women within his patriarchal society. In the 1925 essay, Freud first established the importance of the pre-Oedipal phase in female development. According to Mitchell, by opening up this unexplored period for psychoanalysis, he laid the groundwork for an analysis of femininity as an entity as well as revealing his culture's oppression of women.

20.

Mitchell, Juliet. *Psychoanalysis and Feminism.* New York: Pantheon Books (Random House), 1974. 456 pp.

In this book Mitchell attempts to counteract what she considers feminism's mistaken rejection of Freud and the concepts of psychoanalysis. She contends that psychoanalysis should not be interpreted as a recommendation for the patriarchal system it explores. Instead, it should be seen as offering the tools for an analysis of the system, which is vital for challenging the oppression of women. Mitchell attempts to show how Freudian theory has been distorted by its attackers and how Freud's concept of the unconscious is valuable in providing a sound theory that allows one to understand the workings of the patriarchal culture within the individual. She critically discusses the work of two psychotherapists who have been embraced by the feminist movement, Reich and Laing. Analyzing each man's work, Mitchell points out their misunderstanding of the concept of the unconscious, their confusion of social and psychic reality, and their leanings toward simplistic solutions. Although Reich is seen as offering insights into the politics of sexuality and Laing is cited for his understanding of the oppressive nature of the family, Mitchell contends that neither man offers a sound methodology with which to analyze the nature of society's patriarchal structure. Analyzing the criticisms of Freud posited by the feminist writers de Beauvoir, Friedan, Figes, Greer, Firestone, and Millett, Mitchell places each feminist's work in historical perspective. She suggests that the arguments of these theorists fail because they attempt to discuss Freud's concept of femininity outside the framework of psychoanalysis. Indicating that Reich, Laing, and the feminists offer accurate and valuable perceptions of an oppressive patriarchal culture, Mitchell maintains that only Freud provides the tools for analysis of the patriarchal culture, which must precede any effective cultural revolution. In the final section of the book Mitchell turns to the anthropologist Lévi-Strauss to establish the university of the patriarchal structure in human civilization and, hence, the universal applicability of the concepts of psychoanalysis. Femininity is considered to have developed as a result of cultural, not biological, function. Mitchell concludes that any effective movement to liberate women must be based on an understanding of the "social nonnecessity" of the laws instituted by patriarchy, rather than a simple attack on male domination.

21.

Salzman, Leon. Psychology of the female: A new look. In: Miller, Jean Baker, ed. *Psychoanalysis and Women: Contributions to New Theory and Therapy.* New York: Brunner Mazel, Inc., 1973. pp. 173-189. (Paperback edition: *Psychoanalysis and Women.* Baltimore, Md.: Penguin Books, Inc., 1973. pp. 202-220.)

In this detailed discussion of the psychology of the female, Salzman asserts that the biological and the social reality of a woman's life must both be dealt with if understanding is to be achieved. Freud's influence has made the concept of a woman's psychology as totally dependent on her biological nature difficult to attack. From earliest times the female role has been determined not just by biology but by current technology and prevading religious beliefs as well. A woman's behavior is a result of the role culture assigns her. In recent years there has been much disagreement with Freud's formulation concerning the psychology of the female. The need to study woman as a complete entity influenced by the demands of her culture as well as by her biology has been identified. Physiological research has debunked many of the biological myths about women. Sherfey has shown the primacy of the female sex; Masters and Johnson have shown that the ideal dual orgasm, responsible for causing feelings of inadequacy in many women, is an imaginary concept. A person's sexual development is influenced more by cultural factors than by biological ones. Traits that Freud attributed to the inferior biology of the female are now known to be culturally acquired. Character development in women is based on the demands, restraints, and expectations of her culture rather than on her lack of a penis. As woman becomes less and less divorced from political and economic life, a new image emerges. She is no longer the passive masochist Freud observed. Salzman maintains that the notion of the weak, helpless, submissive female must be abandoned. A psychology that relates character to social and cultural forces as well as biology will facilitate the understanding of changes brought about by new technology which is increasingly breaking down sex-assigned tasks. Men and women must be seen as equal beings with shared needs and desires.

22.

Schafer, Roy. Problems in Freud's psychology of women. ***Journal of the American Psychoanalytic Association*****, 22(3):459-485, 1974.**

In this article Schafer analyzes in detail some of the many problems in Freud's psychology of women, focusing on Freud's theoretical generalizations about women's development and characteristics. Schafer works from the perspective of ego psychology, which views the proper subject of psychoanalytic study to be the whole person developing and living in the context of a complex world. In contrast, Freud worked within the biological-medical tradition of the 19th century with its biological, evolutionary model and value system and its belief in the reality of totally objective empiricism. The questionable assumptions, logical errors and inconsistencies, suspensions of intensive inquiry, underemphasis on certain developmental variables and confusions between observations, definitions, and value preferences that grew out of this tradition, as well as Freud's immersion in the patriarchal society of his day are discussed in three sections. In the first section, "The Problem of Women's Morality and Objectivity," Schafer presents both logical and psychoanalytic objections to Freud's quantitative comparison of the morality of men and women based on Freud's own work. On the question of women's inferior objectivity, or ego development, Schafer indicates that Freud confused his values with his empirical data and failed to acknowledge the effect of the different education and socialization received by boys and girls in their preparation for life in a phallocentric world. In the second section, "The Problem of Neglected Prephallic Development," Schafer stresses the importance of Freud's deeply held "evolutionary value system"—a system that sees all nature as having a procreative plan. Because of this evolutionary model and value system, Freud disregarded his own psychoanalytic insights about human sexuality and his knowledge that for human beings there is nothing inevitable about propagating the species; he neglected prephallic factors in order to center on phallic, or procreative, genitality; and he failed to ask important questions concerning the readiness of girls for castration shock and the precariousness of their self-esteem. In the final section, "The Problem of Naming," such designations and linkages as feminine-passive-masochistic-submissive and male-masculine-active-aggressive-dominant are discussed. Schafer notes that "to designate is also to create and to enforce" and that verbal conventions which implement value judgments are often passed off as unequivocal facts. Although Freud seemed to know he was not making empirical assertions of how men and women really are, he did not always keep definition distinct from observation. Schafer suggests that Freud's generalizations about girls and women do injustice to both his psychoanalytic method and his clinical findings.

23.

Shainess, Natalie. A psychiatrist's view: Images of woman—past and present, overt and obscured. In: Morgan, Robin, ed. *Sisterhood Is Powerful: An Anthology of Writings from the Women's Liberation Movement.* New York: Random House, 1970. pp. 230-245. (Paperback edition: New York: Vintage Books, 1970. pp. 230-245.)

Shainess explores the many views of women that have been held throughout history. Because she sees men and women as interdependent, Shainess holds that woman must be understood within the confines of the life man has allowed her and within a social context. Shainess contends that psychoanalysts have shared historical attitudes about the limited role of women and have therefore failed to acknowledge women as total human beings. An ideal image is needed, rather than a norm, of what a woman might be were she allowed full opportunity to develop. From earliest times women have existed as a subgroup, but without the geographical unity most subgroups have that allows them a sense of oneness and a chance of developing their own culture. Only in recent times have women been organized in any sense as a group. Freud introduced the concept of woman's dual sexual role as mate and then mother, but this theory is too simple in a time when humans have been freed from much that was considered biological necessity. Freud's other theories, like penis-envy, are far more questionable. He was unable to disassociate himself from his Judeo-Christian tradition and the assumptions it made about woman's inferiority. In working with his patient Dora, Freud may have been blinded by his prejudices to what was actually occurring. Despite the rebellion of psychiatrists like Karen Horney and Clara Thompson, classic views of feminine psychology persist, many promulgated by women analysts. They do not deal with the social reality but only with theory. A woman's attempts at self-realization are consequently often defined as a manifestation of her neuroticism. Treatment choices for women can be affected by prejudice that eliminates the inclusion of information in the decision-making process. For example, medical literature frequently mentions female seductiveness but rarely deals with the men involved. Shainess writes that although women's lives are freer than ever before, free from drudge work and from unwanted pregnancy, this freedom may not be liberating. More women are drinking to escape and are willing to do almost anything to evade the confines of their homes. Although agreeing that no one likes to be confined, Shainess feels that a woman is the source of love and care in a family. One problem is that this society places so little value on the home and family and gives few rewards for this work. Shainess suggests that a solution for women might come from a better value system, education, and a society that appreciates the worth of both women at home and women who accept the burden and greater responsibility of interests outside the home. She concludes that psychiatrists must be more aware of their own prejudices and more perceptive in their interpretation of women's behavioral expressions.

24.

Strouse, Jean, ed. *Women and Analysis: Dialogues on Psychoanalytic Views of Femininity.* **New York: Grossman Publishers, 1974. 375 pp. (Paperback edition: New York: Dell Publishing Company, Inc., 1974. 429 pp.)**

This book consists of a series of dialogues. Ten articles written by psychoanalysts were selected to present the development and variety of views, revisions, and departures in psychoanalytic thinking about women; 10 individuals from various disciplines have written essays in response to the anlaytic articles. In her introduction Strouse takes issue with feminism's easy dismissal of Freud on the basis of a simplistic understanding of psychoanalytic theory. The book's intention is to look at some of the theories that have been formulated about women and separate the parts of them that belong to the past from those with lasting value. Strouse suggests that the social, political, scientific, philosophical, and moral contexts in which early psychoanalytic theories were formed can now be seen more clearly than in their own day, and the ideas in these theories that enhance the understanding of women can be selected out in light of new biological, developmental, and cross-cultural information. The first three essays are by Freud. In "Some Psychical Consequences of the Anatomical Distinction Between the Sexes"* (1925), Freud formulates a new theory of feminine development, identifying it as not entirely analogous to that of males. The formulation is responded to in detail by Juliet Mitchell.* Freud's essay "Female Sexuality"* (1931) is replied to by Elizabeth Janeway,* and Margaret Mead* provides an essay on "Femininity"* (1933). After Freud's articles, the pairs of essays are presented in chronological order according to when the analytic articles first appeared. Karl Abraham's "Manifestations of the Female Castration Complex" (1921) is discussed by Joel Kovel; Marcia Cavell responds to Helene Deutsch's "The Psychology of Women in Relation to the Functions of Reproduction"* (1924). Strouse notes that criticism of Freud began as early as 1926 in Karen Horney's article "The Flight from Womanhood."* Horney criticized Freud's masculine bias, and the discrepancy between his observations and theories. Robert Coles provides the commentary. Additional essays include Emma Jung's "On the Nature of the Animus" (1931) discussed by Barbara Charlesworth Gelpi, Marie Bonaparte's "Passivity, Masochism and Femininity" (1934) responded to by Ethel Person, and Clara M. Thompson's "The Role of Women in This Culture"** (1941) examined by Ruth Moulton. Responding to criticism from the women's movement, Erik H. Erikson provides the essay response to his own article, "Womanhood and the Inner Space" (1968). Strouse concludes the book with an essay by Robert J. Stoller, "Facts and Fancies: An Examination of Freud's Concept of Bisexuality" (1973), suggesting that this essay can function by itself as both theory and commentary.

25.

Walstedt, Joyce Jennings. ***The Anatomy of Oppression: A Feminist Analysis of Psychotherapy.*** **Pittsburgh, Pa.: Know, Inc., 1971. 12 pp.**

In her article Walstedt criticizes Freud and challenges the cultural biases and sexist assumptions in psychoanalytic theory that have resulted in the development and perpetuation of harmful negative stereotypes of women. She explains that Freud has now become the focus of study by feminists who are trying to discover the anatomy of their psychological oppression. Quoting from Freud frequently, Walstedt devotes considerable attention to elaborating upon and discrediting his theories, and she charges that Freud dropped the scientific search for truth when he wrote a condescending feminine psychology. Walstedt suggests a review of Freud's letters, writings, and accounts of his personal life for documentation of his extreme prejudice against women. The thesis is offered, with recognition that it would be difficult to prove, "that millions of women have suffered from feelings of shame and sexual inadequacy because Freud himself had a severe castration complex and was 'hung up' on his penis." Freud's "amputation story" is recounted in brief with the comment that the constant retelling of this story by Freud seemed "to bring the comfort that repetition of the nativity story would bring to a religious zealot." The story focuses on a girl's learning that she does not have a penis, and Freud cites several consequences of her "castration." Freud identifies the clitoris as a vestigial male organ, and he contends that the mature woman should give up her clitoris and shift to passive vaginal orgasms as part of becoming feminine. Although Kinsey's definitive study in 1953 showed that less than 14 percent of the women in a large gynecologic sample were conscious of being touched within the vagina and that limited histologic studies of vaginal tissue confirmed the lack of end organs of touch in the vaginal walls, the Freudian bias held by many psychotherapists was strong and Kinsey's study was essentially ignored. In addition to the work of Freud, the theories of Deutsch, Erikson, and Reik are criticized and elaborated upon in this article and compared with those of Adler, Horney, Thompson, and Viola Klein. Although both groups accept the principle that "so-called" male and female traits exist in both sexes, Freud and his followers basically consider the difference in the genitalia as the critical variable affecting personality development. Their psychology of women associates all traits, interests, attitudes, neuroses, and emotions to the absence of a penis. Adler, Horney, Thompson, and Viola Klein, in contrast, acknowledge the obvious sexual differences but attribute more significance to how the biological individual develops as a result of both interpersonal relations and interaction with the culture. Walstedt considers her own theoretical foundations as compatible with the culturally oriented group. The effects of Freud and the Neo-Freudian group on the mass media are discussed. Walstedt believes that "Freudianization" of the mass media has helped many women to internalize harmful and negative stereotypes. Women have been taught to feel ashamed of efforts in their own behalf and guilty if they try to achieve something for themselves. A feminist therapist, defined as a person who is supportive and understanding of the need for female equality, is recommended as a means to help women rethink their identity. The therapy process would be a democratic one and would deal with the negative influences in the culture. A feminist therapist is identified as one who can give the woman the courage she needs and can function as a model for the development of a new set of norms. The need for a radical new therapeutic psychology which gives women the strength to do battle with the culture that has consistently blocked their development is emphasized.

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*Abstract of article included in this bibliography.

**Abstract of article from another source included in this bibliography.

26.

Wittkower, E.D., and Robertson, B.M. Sex differences in psychoanalytic treatment. *American Journal of Psychotherapy*, 31(1):66-75, 1977.

This three-part article is based on a review of psychoanalytic literature and the authors' experience as practicing psychoanalysts. The first part deals with sex stereotypes, and the authors note that historically women have represented both good and evil. The sterotype of woman in modern North American society portrays her as both passive and dependent, tender and compassionate, pleasing to all senses, devoted to children, and nurturing. According to this stereotype, a woman should be sexually attractive but must never make advances. The authors contrast this to the male stereotype, and they suggest that the major differences between the female and male stereotypes lie in inhibition. Women are expected to be more inhibited in the expression of aggression and men in the expression of emotion. The second part of the article focuses on clinical observations, and the psychoanalytic process is briefly described. The authors report that men and women working with male analysts show differences in the resolution of the Oedipus complex through transference. Women more often reproduce and reexperience loving feelings, while men have more feelings of hostility. The Authors point out that the literature makes little reference to transference differences caused by sex. The final segment of this article is concerned with psychoanalytic theories of sexual differences. The authors present a historical review and cite objections to Freud's theories on female sexual development made by Horney, Jones, and Melanie Klein. These psychoanalysts did not attach as much significance to penis-envy as Freud did. Rather, they emphasized the female's early relationship with her mother as being crucial in her sexual development. The authors point out that Freud has been criticized by analysts for his phallocentric view, which has been considered a reflection of the cultural bias against women. Although the findings of Masters and Johnson cast doubt on some of Freud's sexual theories, the authors report that these findings have brought no real breakthrough in the psychoanalysis of women. It is now generally accepted that Freud was incorrect in asserting that girls experience no vaginal sensations until puberty and in underestimating the developmental importance of the pre-Oedipal phase. The authors conclude that anatomy is fate and that biological differences between the sexes clearly exist. They acknowledge, however, that early relationships, social impositions, and expectations also powerfully influence differences between the sexes.

27.

Yorburg, Betty. Psychoanalysis and women's liberation. *The Psychoanalytic Review*, 61(1):71-77, 1974.

Yorburg begins this article by noting that the women's liberation movement has legitimate economic and political goals and by suggesting that its leaders have only to continue their efforts against political and economic discrimination to achieve their objective. She goes on to assert that the ideological problems of the movement are quite a different matter. Fighting attitudes, values, and beliefs and how they affect sex role definitions is a much more difficult battle, because the real enemy is cultural tradition rather than those who may have been influenced by it. Psychoanalytic theory's inferences about the natural inferiority of women are identified as culture-bound, and Yorburg contends that these are currently being revised or discarded. The author believes that women are "beating a dead horse" in attacking specific theoretical formulations of psychoanalysis about feminine psychology and sexuality. She discusses the concept of womb envy and Bettelheim's work on male envy of women, suggesting that attacks on psychoanalysis are a waste of energy and are simply concerned with words—that envy between the sexes is linked to the relative status of the sexes in the society. Additionally, she maintains that other Freudian formulations about the passive, masochistic, dependent nature of women are no longer regarded as accurate. Freud is cited to support the assertion that his theory is not so rigid as it is portrayed to be. Yorburg asserts that the psychoanalytic theory of the past served the needs of that society and that it is now changing to meet the needs of today. The definition of self-fulfillment that is presented as the standard of psychoanalytic treatment is viewed as also changing with the society and the culture. The controversy over vaginal versus clitoral orgasm is defined as "a storm in a teacup," with the author claiming this issue to have been of little consequence for most women. Instead, she regards Freudian theory's emphasis on the importance of the sex drive and consequences of repression for both sexes as having been far more important in changing role behavior in America. It provided the ideology for the sexual revolution that occurred in the 1920's, one that grew out of the technological changes in the society. The author concludes by suggesting that the sexual liberation of women is still incomplete. Psychoanalytic theory about the strength of the sex drive and the importance of sexual gratification is identified as still relevant to dispelling the guilt and anxiety that continue to prevent many women from fully enjoying their sexuality.

New Theory and Research

28.

Compton, Ariel S. Who's hysterical? *Journal of Sex and Marital Therapy*, 1(2):158-174, 1974.

In this article Compton examines the character traits of the hysterical personality and questions whether these traits are distinguishable from normal feminine traits. She identifies her sources for the character traits of "normal" women as Simone de Beauvoir's *The Second Sex*, her own personal experience, and a wide variety of reading. Compton believes that descriptions of the hysterical personality lack the preciseness of other diagnoses and she discusses some of the semantic confusions that surround the term hysteria. Indicating that the traits designating the hysterical personality are very elusive, Compton presents a historical review of hysteria to promote an understanding of its symptoms. From earliest times there has been confusion as to what was pathology and what was "the nature of women." Drawing from studies by Lazare and Shapiro, Compton presents the character traits that appear to define the hysterical personality: (1) egocentricity; (2) exhibitionism; (3) emotionality; (4) dependency; (5) sexual provocativeness; (6) fear of sexuality; and (7) a hysterical or global style of cognition. Each one of these traits is described and is shown to be as much a characteristic of the feminine role in this culture as a characteristic of the diagnostic entity known as the hysterical personality. Compton presents Freud's theory of female development, which was based on his assumption of woman's biological inferiority, and she suggests that this assumption would allow one to anticipate these so-called "feminine" character traits. She points out, however, that women's character traits can also be understood as stemming from the reality of the position they occupy in society. Conflicts can be seen as arising out of woman's desire to retain her sexuality while not wanting to accept a subordinate position that suppresses her identity and retards her development. Compton notes how the masculine orientation has managed to maintain control over the understanding of woman's psychosexual development despite the critical work of people like Horney and Thompson. She identifies the women's movement as responsible for modifying thinking. Compton indicates that new evidence from the biological sciences is facilitating a reexamination of psychoanalytic views, although there is still resistance to change. She contends that if therapy is to prove helpful, a revision must be made in the understanding of female psychosexual development and of the hysterical personality, and an ongoing awareness of cultural factors must be introduced into treatment. Woman's predisposition to hysteria may be the result of cultural demands that require her to repress drives that are basic to mature development, because they are defined as masculine. Hysterical symptoms can be identified as a reaction to a male-dominated environment that places many women in a position of retarded development, submission, dependence, and necessary sexual repression.

29.

Masters, William H., and Johnson, Virginia E. *Human Sexual Response.* Boston: Little, Brown and Company, 1966. 366 pp.

Reporting on 11 years of research Masters and Johnson identify their basic interest as determining what men and women actually do in response to effective sexual stimulation and why they do it. Their primary research techniques were direct observation and physical measurement. The research sample, 328 women subjects (mostly aged 18 to 40) and 312 male subjects (mostly aged 21 to 40), was heavily weighted toward higher than average intelligence levels and socioeconomic backgrounds. In order to provide a more concise picture of physiologic reaction to sexual stimuli, Masters and Johnson divide the human male's and female's cycles of sexual response into four phases—the excitement, the plateau, the orgasmic, and the resolution phases. After presenting evidence of physiologic response to effective stimulation in other than the target organs of female reproduction, Masters and Johnson focus on the anatomy and physiology of female external genitalia—the labia majora, the labia minora, and the clitoris. They report that there normally is marked variation in the anatomic structuring of the clitoris during periods of sexual stimulation, that the first pelvic response to sexual stimulation is the production of vaginal lubrication, that the rapidity of clitoral response is dependent upon whether the stimulative approach is direct or indirect, and that manipulation of the clitoral body or the mons area is the only direct approach. Clitoral response at each phase of the sexual response cycle is discussed. Regardless of positioning and type of coition or erogenous areas manipulated, the reactions of the clitoris to successful sexual stimulation follow the same physiologic response patterns. Considering clinical application of the basic knowledge they have accumulated concerning the clitoris, Masters and Johnson point out that sexually responding women achieve orgasmic levels of sexual tension without regard to variables in basic anatomy and physiology of the clitoris, that only the female superior and lateral coital positions allow direct or primary stimulation of the clitoris to be achieved with ease, that women rarely report or have been noted to use direct manipulation of the clitoral glans when masturb[illegible] and that the primary focus for sexual response in the human [illegible]le's pelvis is the clitoral body. Finally, they maintain that the definitive role of the clitoris in sexual response must be recognized if there is to be effective treatment of female sexual inadequacy. In concluding their discussion of the role of the clitoris in female sexuality, Masters and Johnson assert that from a biologic point of view clitoral and vaginal orgasms are not separate anatomic entities and that there is absolutely no difference in the response of the pelvic viscera to effective sexual stimulation, regardless of the form the stimulation takes. Duration and intensity of orgasmic experience may vary, but when any woman experiences orgasmic response to effective sexual stimulation, the vagina and clitoris react in consistent physiologic patterns. The authors discuss the anatomic and physiologic reactions of the vagina in its role as the physical means for expression of sexual capacity and consider the efficiency of the vagina in conceptive physiology; they report that the uterus has been observed to respond to sexual stimulation as a composite organ and that individual reaction patterns for the corpus and cervix have been recorded and observed; they present material reflecting the influence of pregnancy upon female eroticism; and they describe and discuss physiologic, psychologic, and sociologic aspects of the female's orgasmic experience. Masters and Johnson identify two major areas of physiologic difference between female and male orgasmic expression other than ejaculation--the female is capable of both rapid return to orgasm immediately following an orgasmic experience and of maintaining an orgasmic experience for a relatively long period of time. The maximum physiologic intensity of orgasmic response subjectively reported or objectively recorded has been achieved by masturbation and the lowest intensity of response was achieved during coition. Additionally, the authors devote four chapters to male sexual response, two chapters to consideration of the sexual response of the aging male and female, and a final chapter to the presentation of case histories.

30.

Miller, Jean Baker, ed. *Psychoanalysis and Women: Contributions to New Theory and Therapy.* New York: Brunner Mazel, Inc., 1973. 418 pp. (Paperback edition: *Psychoanalysis and Women.* Baltimore, Md.: Penguin Books, Inc., 1973. 415 pp.)

In her introduction Miller notes that psychoanalytic ideas have dominated the modern conception of women. The writings in this book, all by prominent psychoanalysts, present a view of women that differs from commonly known psychoanalytic formulations. A new outlook on the psychology of women is offered, and new scientific data from biological research are incorporated to augment this view. Miller maintains that the articles in this book form a body of material from which one can focus on the problems women are facing today as they seek to change their traditional roles and grow as full human beings. She reports that the psychology of women has long been a subject of contention within the psychoanalytic movement. The first part of the volume, "Pertinent Pioneers," comprises essays by some early questioners of Freud's conception of women—Karen Horney,* Alfred Adler,* Clara Thompson,** Frieda Fromm-Reichmann, and Gregory Zilboorg. Freud's phallocentric orientation is criticized and the feminine character Freud observed is identified as the product of cultural influences and woman's role in society rather than as having been biologically determined. Part II, "The Emergence of New Evidence," presents recent essays that draw upon new biological and clinical data. Mary Jane Sherfey** presents a new formulation about female sexuality, which she relates to the origin of human civilization and the development of culture. Mabel Blake Cohen discusses the incompatibility between traditional sex role definitions and the optimum development of the individual's assets as a person. Paul Chodoff examines Freud's theory of infantile sexuality, which forms the basis of his perceptions of women, in light of modern scientific perspectives and data. Leon Salzman* relates the female character to social and cultural forces. Judd Marmor examines the psychoanalytic implications of woman's changing role. Ruth Moulton presents a review of the concept of penis-envy using current clinical and psychological data as well as material drawn from her own practice. Robert Stoller is represented by two essays, "The Sense of Femaleness" and "The 'Bedrock' of Masculinity and Femininity: Bisexuality," in which he integrates current work in biology and psychology. The final section of the book, "Present Problems and Some Future Possibilities," includes an article by Alexandra Symonds* about women who develop phobias after they are married as well as three articles by Robert Seidenberg. In his three articles Seidenberg points out the cultural realities that give women the character traits Freud saw as innate, discusses the possibilities for future equality between the sexes, and focuses on the case of an agoraphobic housewife. Lester Gelb is represented by an article in which he discusses the societal devaluation of women. In a concluding chapter Miller reviews these essays, identifying their contributions and the new issues that are emerging concerning the development of women.

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*Abstract of article included in this bibliography.

**Abstract of article from another source included in this bibliography.

31.

Moulton, Ruth. Some effects of the new feminism. *The American Journal of Psychiatry*, 134(1):1-6, 1977.

In this article the author compares 25 women patients she treated between 1953 and 1956 with 25 she treated between 1973 and 1976. She notes that the last 20 years have been a time of rapid cultural change, change that has disturbed the established psychological equilibrium. Of the 25 women in the early group, 10 were seeking help because of sexual problems, some form of frigidity. The most prominent symptom of 10 other women was their desperate need to find a husband. All these women suffered from great inhibitions. In contrast, the women treated during the period from 1973 to 1976 had much freer attitudes, did not find sex major problem, and, as a group, were more involved with professional careers and concerned about the realities of marriage and the possibilities of its becoming a trap. After comparing these two groups of women, Moulton describes problems she has observed to be increasing—problems that are manifestations of rapid cultural change. The first of these is the reentry anxiety that many women face as they are about to rejoin the outside world after an absence of 10 or 15 years. Much analytic time is devoted to understanding the "inner barriers" that make these women so fearful.

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*Abstract of article from another source included in this bibliography.

Examples are given of the possible roots of this fear much earlier in the women's lives. Performance anxiety is another current problem. Even women who have professional positions are afraid to assert themselves publicly because of childhood fears of male aggression and punishment for not conforming to parental ideas of feminine behavior. The third problem area the author terms the "good girl" syndrome. Many women who rose to executive positions in the male world did so by maintaining a self-effacing style that pleased those in control. When they came to hold more responsible jobs, they found themselves fearful of being on their own and having to answer for their own decisions. They had difficulty standing up for themselves and their work without the protection of men in superior positions. An example of this syndrome and how it was resolved is provided. The special problems of women who have to assert themselves to gain their place in the academic world are also presented. Another section of the article is devoted to the effects role strain is having on many men. Moulton concludes that while the new feminism has created many new options for both sexes, it has also unleased new anxieties. She suggests that therapy can help those people who feel a need to change their lifestyles, but that this desire should come from the patient rather than from the therapist.

32.

Sherfey, Mary Jane. A theory on female sexuality. In: Morgan, Robin, ed. *Sisterhood Is Powerful: An Anthology of Writings From the Women's Liberation Movement.* New York: Random House, 1970. pp. 220-230. (Paperback edition: New York: Vintage Books, 1970. pp. 220-230.)

This article suggests that the most far-reaching hypothesis drawn from current biological data is the universal and normal physiological condition of woman's inability to reach complete sexual satiation despite repeated and intense orgasmic experiences. This does not mean that she is never satisfied—she may be—but merely that she cannot be satiated as the male can. Related to this hypothesis are the findings of Masters and Johnson that most cases of coital frigidity are due to the absence of frequent and prolonged coitus. These new findings on women's sexuality support the idea that neither men, nor especially women, were built for the single mate monogamous marriage. Sherfey hypothesizes that women have been forced into monogamy, because permanent family and kinship are necessary for the development of civilization. Primitive woman's cyclic sexual drive was too strong to maintain any family cohesion; therefore family life could not begin until enforced social codes brought sex drives under control. Prehistory studies suggest, however, that it may have taken 5,000 years or longer for the subjugation of women to be accomplished. The question is raised as to whether the female sexual drive has abated as a result of 7,000 years of suppression. Now that injunctions against the expression of female sexuality have been lifted by the tide of the scientific revolution with readily available contraceptives and by an attitude of social equality and emotional honesty, new enforced sexual suppression may be necessary to preserve the institution of the family. Sherfey presents biological data that indicate all embryos begin as female and discusses how this contributes to an understanding of female sexuality. She also discusses the finding of Masters and Johnson that there is no distinction between clitoral and vaginal orgasm, their description of the nature of the labial-preputial-glandular mechanism which maintains continuous stimulation of the retracted clitoris during intravaginal coition, and their finding that with full sexual arousal, women are normally capable of many orgasms. Sherfey suggests that although these new biological findings may require some not too large amendations of psychoanalytic theory, they will strengthen the theory and practice of psychoanalysis in the field of female sexuality. She expresses her hope that the data presented will form a biological foundation upon which to base future theories of female psychosexuality.

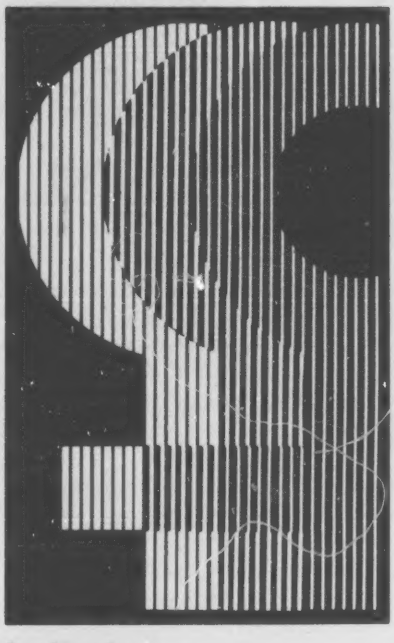
33.

Symonds, Alexandra. The liberated woman: Healthy and neurotic. *The American Journal of Psychoanalysis*, 34(3):177-183, 1974.

On the basis of her experience with patients, Symonds discusses the neurotic and healthy efforts of women to free themselves and to assert their identity. The "psychology of submission" that was created by traditional attitudes toward women is identified as harmful to women's emotional growth and development and to their self-concept. Referring to Horney's concept that to be healthy a human being must develop her needs and potential in three main areas—dependency, detachment, and expansiveness—Symonds asserts that social pressures have caused women to develop only one-third of their potential. Since healthy needs in the areas other than dependency cannot be developed, neurotic character patterns are formed. The dependent personality society demands of women is called feminine, as if biologically determined, and its traits are perceived as normal for women. Symonds contends, however, that woman's restriction of her potential creates a skewed personality that is ill equipped for constructive growth. Women become focused on others for their sense of self-worth. She presents an example of how the culture provides material and models for masculine and feminine character structure, and the case of a teenage girl who typifies the traditional feminine character structure. Symonds points out that without any experience or encouragement in developing self-sufficiency and assertiveness, it is virtually impossible for women to maintain an "authentic existence" (de Beauvoir). Merely gaining rights on paper does not give women either the ability or desire to grow. Symonds discusses the sources of anxiety that often make women consciously or unconsciously resist growing toward healthy self-assertion. The dependent person fears change, because she is alienated from her inner resources and change is experienced only as loss. This fear sometimes causes her to become phobic. According to Symonds, one of the greatest handicaps dependent people have is an inability to initiate action and accept its consequences. As a result, they often become masters of indirect action or manipulation. Acknowledging this handicap would cause intrapsychic pain, so they often accuse others of creating this situation; if the other people would change, everything would be fine. Examples are included of a "liberated" woman who took this route and another who realized she could overcome her dependent patterns. Symonds points out that in order to achieve autonomy, one must overcome these fears and learn a certain amount of aggression and self-assertion. Women have been conditioned to view assertiveness as a masculine trait, and their fear of self-assertion is identified as a major block to full development. To be liberated, women need to deal with all these fears.

II.

CRITICISM OF THE TREATMENT OF WOMEN



Sexism in
Traditional Psychotherapy
Sexism in Other Treatment

Sexism in Traditional Psychotherapy

34.

Barrett, Carol J.; Berg, Pamela I.; Eaton, Elaine M.; and Pomeroy, E. Lisa. Implications of women's liberation and the future of psychotherapy. ***Psychotherapy: Theory, Research and Practice,*** **11(1): 11-15, 1974.**

The feminist authors of this article assert that current personality theories present a largely masculine perspective. Women are viewed negatively in such terms as inferior, competitive, castrating, overemotional, dependent, and weak. Although most personality theories create polarities of positive masculine and largely neglected feminine traits, the goal of psychotherapy should be to integrate these traits. The majority of patients in psychotherapy are women, and a study by Schofield (1969) found that women have more problems with their adjustment and self-perception and have more physical and psychological symptoms than men. Despite this fact women are only minimally represented in the most prestigious mental health professions. The authors indicate that it is unclear whether male and female therapists differ in their values about women, referring to the study by Broverman et al. that suggests they do not. They cite Chesler (1971) concerning similarities between individual psychotherapy and the institution of marriage and how traditional therapy merely helps women accept their oppressed lot without ever acknowledging that their symptoms are caused by this very oppression (Szasz, 1961). Women's internalization of society's negative perception of them is identifiable in their preference for male therapists whose contempt for them may go unnoticed, because it coincides with their own self-image. In line with this, the authors identify exploitation of their patients by male therapists as a blatant example of antitherapeutic practice. They also point out that therapy fails women by not dealing seriously with the crises of large groups of women—women who find themselves facing situations that run counter to traditional role training and expectations such as abortion, marriage-career conflict, and widowhood. Suggesting that women's liberation poses radical changes in theory, goals, techniques, and training, the authors recommend that therapists communicate their personal values to clients; that the theory that motivates psychotherapy deal with the entire life cycle and stress each individual's potential; and that therapy foster freedom to choose alternative life styles, with the goal of enhancing autonomy. They consider assertion training to be useful in helping women to achieve these goals and suggest developing techniques to deal with women's fear of success. Consciousness-raising groups are identified as providing a model for psychotherapy in breaking down the isolation many women feel. Although the potential value of male and female co-therapists is recognized, the authors warn that these teams must be careful not to reinforce sex stereotypes. The article is concluded with the recommendations that more women therapists be trained and that consciousness raising groups might prove useful for all therapists in helping them change their attitudes about the limitations of the sexes.

35.

Beesly, Mary G. Critical evaluations. "Modern Woman: Implications for Psychotherapy." I. Psychotherapy and evolving social-sexual roles. *Canadian Psychiatric Association Journal* (Ottawa), 18(1): 83-84, 1973.

In this criticism of Stephenson ("Modern Woman: Implications for Psychotherapy"* (1)), Beesly is concerned with the credit Stephenson gives to the New Feminists for changing the social-sexual role of women. Beesly views this change as part of an ongoing evolutionary process. She contends that radical feminists are misdirected in their attempts to reform social-sexual roles by attacking myths and myth makers. Instead, she suggests they should recognize the true historical causes for woman's inferior status and deal with present realities. Beesly asserts that most men and women today would be ready to acknowledge the mythical nature of inferior-superior sex stereotypes. She believes it is important that the true nature of the sexes be recognized. Psychotherapy and psychoanalysis are identified as concerned with intrapsychic processes that can help people achieve the freedom to explore their roles. Beesly does not consider these disciplines to be involved with the development of social theory and the reinforcement of specific social-sexual roles, but she does believe that they can be valuable tools in contributing to the social-sexual evolution.

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*Abstract of article included in this bibliography.

36.

Bernardez-Bonesatti, Teresa. Psychotherapists' biases towards women: Overt manifestations and unconscious determinents. Paper presented at the 128th annual meeting of the American Psychiatric Association, Anaheim, Calif., May 5-9, 1975.

Basing her discussion on her work with patients, supervision and training of other therapists, and observations of colleagues, Bernardez-Bonesatti concentrates on the potentially harmful way therapists behave toward their female patients. She claims that this behavior stems from unconscious emotionally charged cultural attitudes toward women that may actually be in opposition to the theoretical support for role change the therapists hold consciously. Some of the most common instances of therapists' reactions and interventions that reveal a prejudiced perception of women and interfere with the patient's optimal growth are presented. Women whose behavior is openly hostile or who have a domineering attitude often provoke a strong moral repudiation from therapists that would never be extended to men presenting such an image. Although the therapist may restrain his reaction in front of the patient, he often openly derides the client to colleagues. This adherence to role stereotypes may also appear in family therapy sessions where patients who do not present the proper behavior—dominant man, submissive woman—often do not receive the assistance they require. Bernardez-Bonesatti reports the negative reactions of her male colleagues when she formed all-women therapy groups. These therapists clearly feared that the women would be domineering and angry and would want to take revenge on men. She suggests that the therapists who perceived these dangers were providing support for the idea that women have, in fact, been "kept down" and, if "liberated," would feel justified in imposing similar treatment upon men. A corresponding fear of unleashed female anger is evident in the behavior of therapists who fail to delve into their female patients' clearly pathological submissiveness and self-effacement, because it conforms to cultural expectations. The author believes that this common error in judgment is responsible for many less than successful treatment outcomes. She suggests that this behavior by male therapists reveals a fear of female destructiveness. Therapeutic literature is mentioned as showing a similar belief in the inherent cruel and destructive behavior of women. The author cites Horney (1967) and Melanie Klein (1957) to support the view that the source of fear may be envy of female power in the mother-infant relationship. She also indicates that this fear may come from an understanding of how suppression of women's rights as human beings breeds resentment. The author concludes that women's powerlessness in the other aspects of their lives may well lead to tyrannical and destructive behavior toward their children. She suggests that if therapists can be open to helping women express their anger and satisfy their own needs, they will also be making healthy development possible for children. For this to be accomplished, long-held irrational notions about woman's destructiveness and man's vulnerability have to be disregarded.

37.

Chesler, Phyllis. Marriage and psychotherapy. In: Agel, Jerome, ed. *The Radical Therapist.* New York: Ballantine Books, Inc., 1971. pp. 175-180.

This article analyzes similarities in the institutions of psychotherapy and marriage, which, according to Chesler, are the two major socially approved institutions for women. Both psychotherapy and marriage isolate women from each other and both are based on woman's dependence on an authority figure. Chesler indicates that both institutions can be viewed as methods of socially controlling and oppressing women and that psychotherapy often serves to shore up marriage by encouraging intrapsychic rather than political interpretations of dissatisfactions. Chesler contends that in both institutions men control the talk of women. The potentially liberating concepts and values of psychoanalysis are held to have been institutionalized so that the psychotherapeutic encounter has become just one more repetition of woman's unequal role in society. Chesler questions whether such a structure can encourage independence, or even healthy dependence, in women. Male therapists are viewed as unable truly to empathize with women even if they achieve the unlikely possibility of freeing themselves from sexism. Chesler also points out that female therapists may be just as oppressive in their treatment of women. On the basis of her analysis of the similarities between marriage and psychotherapy, Chesler concludes with the following practical suggestions: therapists must learn to recognize the stereotypes they hold concerning women, the unconscious power strategies that are typically involved, the "stifling nature of the therapeutic interaction"; women patients should seek women therapists who are feminists; all women should join some aspects of the Women's Liberation Movement; and all-female therapeutic communities should be established.

38.

Chesler, Phyllis. Patient and patriarch: Women in the psychotherapeutic relationship. In: Gornick, Vivian, and Moran, Barbara K., eds. *Woman in Sexist Society: Studies in Power and Powerlessness.* New York: Basic Books, Inc., 1971. pp. 362-392.

Chesler documents her assertion that more women than men "go crazy" with the statistics of the National Institute of Mental Health study for the period 1965 to 1967. During that time period, 102,241 more women than men were reported to be receiving care in private psychiatric hospitals, state and county psychiatric hospitals, inpatient psychiatric wards in General and Veterans' Administration Hospitals, and General and Veterans' Administration outpatient psychiatric facilities. The figure does not include those individuals receiving various forms of private treatment other than hospitalization in the United States. Regarding the symptoms of women in treatment, Chesler discusses a study of Zigler and Phillips in which the women patients were more frequently found to exhibit self-deprecatory, depressed, perplexed, and suicidal behavior. Responding to the question of why more women than men seek and receive treatment, the author suggests that psychotherapists have traditionally described as mental illness the symptoms and signs of various kinds of real and felt oppression—and women, who have been oppressed in this society and who are conditioned to a sex-role stereotype that consists of these signs, often exhibit "mentally ill" behavior. She also suggests that there may be more women in therapy, because therapy and marriage are the two socially approved institutions for middle-class women. The fact that these two institutions are similar is significant. Psychotherapy for women is another unequal relationship. Psychotherapy and marriage are similar in that (1) both are based on a woman's dependence on a male who is regarded as stronger and as an authority figure; (2) individual rather than collective solutions to a woman's distress are sought; (3) a refuge is provided that simultaneously controls and oppresses the woman; and (4) a means for the safe expression of anger is offered, for the anger becomes identified as a form of emotional illness. Chesler refers to studies that show a preference for female patients among psychiatrists, psychologists, and social workers (Schofield, 1960) and a difference in clinicians' concepts of a mentally healthy adult male and female (Broverman et al., 1970). Male psychologists, psychiatrists, and social workers are advised that they know nothing about their women patients, that their diagnoses and sympathy are both harmful and oppressive, and that they should stop treating women. Chesler recommends that all women, both clinicians and patients, become involved in or at least give serious thought to the women's movement. She concludes that women wanting therapy should go to female clinicians who are feminists, and female clinicians, along with all women, should work toward the creation of a new psychology of women and act on it as a group.

39.

Chesler, Phyllis. *Women and Madness*. Garden City, N.Y.: Doubleday & Company, Inc., 1972. 359 pp. (Paperback edition: New York: Avon Books, 1973. 359 pp.)

In this book Chesler, a psychologist and a feminist, writes about female psychology. She describes the relationship between the female condition and what is termed madness in our society and cites the increasing numbers of American women who are perceived or who perceive themselves as "neurotic" or "psychotic." Questions addressed include: "who" seeks psychotherapeutic help or is psychiatrically hospitalized; "why" help is sought; "what" is experienced and considered as in need of help; and "how" women are or are not helped. The book is extensively documented, and Greek mythology is used throughout for the purpose of illustration. Chesler explains how female reproductive biology, patriarchal culture, and the modern parent-daughter relationship have combined to perpetuate characteristically female behaviors and ideals, such as self-sacrifice, masochism, and dependency, as well as the overwhelming dislike and devaluation of women. Chesler identifies both the mental asylum and private therapy as mirrors of the female experience in the family. She presents a different way of understanding male and female psychiatric syndromes, indicating that most women display "female" psychiatric symptoms—depression, frigidity, paranoia, psychoneurosis, suicide attempts, and anxiety—in contrast to the "male" problems of alcoholism, drug addiction, personality disorders, and brain diseases. According to Chesler, schizophrenia, or madness, is basically different from female symptoms such as depression or anxiety. Schizophrenia, in both sexes, always involves opposite as well as same-sex behavior. What is considered "madness" in either women or men is the acting out of the devalued female role or the total or partial rejection of one's sex-role stereotype. Women who fully act out the conditioned female role are clinically viewed as "neurotic" or "psychotic" and are hospitalized for predominantly female behaviors such as "depression," "suicide attempts," "anxiety neuroses," "paranoia," or "promiscuity." Women who reject or are ambivalent about the female role are hospitalized for exhibiting less "female" behaviors such as "schizophrenia," "lesbianism," or "promiscuity" (identified as both a "female" and a "nonfemale" trait). Chesler reviews traditional and contemporary clinical theories and practices. She discusses the major biases of clinicians, who are predominantly male, and who are seen as having maintained a double standard of mental health and treatment for men and women and for different classes and races. United States "mental illness" statistics for the period 1950 to 1968 are presented as documentation of the extent to which more women than men are involved in "careers" as psychiatric patients. Sixty women interviewed by Chesler about their experiences in private therapy and mental asylums were sought out because they (1) had had sexual relations with their therapists; (2) had been hospitalized in mental asylums; (3) were lesbians; (4) were Third World women; or (5) were feminists in therapy. Chesler details their extensive involvement with the "mental illness" profession and compares their experiences. These experiences are related to Chesler's view that the direction of the career of a female psychiatric patient is influenced by the extent to which the "feminine" role is accepted or rejected, as well as by the woman's age (or "expendability"), race, class, and marital status. She discusses her interviews with each of the groups of women, indicating that only a minority of them experienced what she would consider genuine states of madness; most were simply unhappy and self-destructive in typically (as well as approved) female ways. In the asylums many of the women worked as domestics for no or token payment, were medically abused or neglected, sexually repressed or exploited, ridiculed and abandoned by family and professionals, and given little "therapy" of any kind. The women who could affort the best available verbal treatment were not always or often understood or helped. In the book's concluding chapter, Chesler discusses "Female Psychology: Past, Present, and Future."

40.

Dahlberg, Charles Clay. Sexual contact between patient and therapist. *Contemporary Psychoanalysis,* **6(2):107-124, 1970.**

The objective of Dahlberg's paper is to provoke discussion and clarification of the issues involved in sexual contact between patient and therapist. He suggests that therapists who have sexual relationships with their patients rationalize their behavior as in the best interest of the patient. James L. McCartney's paper, "Overt Transference," is identified as the only work that encompasses sexual intercourse as a psychotherapeutic modality, and McCartney's theory in support of this view is presented. In a review of the available literature, Dahlberg refers to Freud's paper on transference love in which the analyst is warned against taking any personal advantage of the patient sexually. Fromm-Reichmann's view of why love making and psychotherapy are incompatible is also discussed. Nine brief, fragmentary case histories, in which Dahlberg was provided firsthand information from one of the parties involved, are presented. These cases, which range from the relatively harmless to the clearly destructive, are considered to be cases of neurotic acting out by depressed or sociopathic and frequently grandiose therapists who have lost control of their actions. Dahlberg indicates that where the information is available, the therapist is always a male over age 40 and 10-25 years older than the patient; with the exception of one homosexual case, the patient is always a young female. In three cases where there is additional information, the therapist is either separating or was just recently divorced from his wife. Noting that there is too little information to make any diagnostic or psychodynamic formulations about either the patient or the therapist, the author nonetheless speculates on the matter of age and develops a composite psychotherapist, presenting a possible course of events that led to his sexual involvement with the patient. Dahlberg indicates that the themes that emerge from the patients' feelings in these cases are of triumph, betrayal, and exploitation. Conceding that there is little question that a patient can arouse the therapist's anxiety, hostility, or sexuality, Dahlberg claims that the issue is how the therapist should behave verbally and physically when so aroused. The overriding rule must be that anything the therapist does should be in the patient's best interest or at least not harmful to the patient, and sexual acting out cannot be in the patient's best interest. Dahlberg concludes with a proposal for a Kinsey-type survey of therapists and patients in order to investigate the circumstances and results of sexual acting out and near acting out.

41.

Fields, Rona M. Psychotherapy: The sexist machine. Paper presented at annual meeting of the American Psychological Association Symposium, Honolulu, Hawaii, September 1972.

Fields asserts that clinical and therapeutic psychological theories have viewed women as inferior to men in all ways and that the practices developing from these theories reinforce prejudiced attitudes toward women and lead to further discrimination. Stereotyping of female behavior also hinders accurate data collection about women's problems, such as drug addiction and alcoholism. Chesler is cited concerning the sexist nature of the institution of psychotherapy; i.e., women are far more likely to become patients and to remain in therapy longer than men because sexual stereotyping encourages this. Fields views psychotherapy itself as the problem. Psychology has perpetuated norms and then labeled those who fail to meet them as "sick." Examples are given to illustrate how the various schools of psychology are all sexist at their base. She suggests that the pervasiveness of sexism in the field demands that psychologists reexamine the literature and curriculum of their programs in order to develop new theories and approaches that are consistent with the changing role of women in society. Case histories of three women who were the victims of sexism when they undertook psychotherapy are presented. The ongoing problem of professional legislation of ethics to eliminate sexual abuses of women is identified in a description of a county psychological associations's meeting to discuss "Sex, Ethics and Psychotherapy." Fields concludes that in order to change the effect psychology has on women, the entire process, especially the administration of the ethical code, needs to be reworked. It must be made as dishonorable to objectify a human being or to exploit a woman's sexuality as it now is to misrepresent one's qualifications or practice without a license.

42.

Gardner, Joann. Sexist counseling must stop. *Personnel and Guidance Journal*, 49(9):705-714, 1971.

Gardner begins her article by identifying two outstanding characteristics of the feminist movement—its challenge of all traditional stereotypes and standards for female behavior and its questioning of every model for producing changes. She then proceeds to list and discuss the basis for five demands for change in the lives of women that are based on the feminist goal of eliminating sex-role stereotypes. As part of this discussion, a chart and figure is presented that analyzes the similarities between two oppressed groups—blacks and women. In her discussion of counseling, Gardner reports that the counselor's traditional role is being challenged. There is a recognition that counselors need to have their consciousness raised about their own needs and how they influence counseling relationships. The movement is away from one-to-one counseling relationships to group contacts. Moreover, the attitude that clients must be helped to adjust is increasingly giving way to the attitude that the system may need to change. The feminist movement's consciousness-raising groups are described and identified as particularly relevant to counseling and the best method for producing feminists. Gardner asserts that a necessary characteristic of the ideal counselor is that she/he be a feminist. The research of Broverman et al. and Chesler's work on the sexist nature of therapy are cited, and it is suggested that only those with special training in feminism can create conditions that will enable women to exercise fully their right to select goals. Nonsexist counselors with a consciousness that makes them strive toward adjusting the system rather than the individual are identified as a necessity. The following steps toward a new and nonsexist design for living are presented: (1) the elimination of unscientific myths about the nature of women; (2) the establishment of interdisciplinary female studies programs and institutes to encourage research about women; and (3) the revision of texts and curricula to eliminate sexism. The author concludes that if counselors are to be truly helpful to women, they must take courses taught by feminists, participate in consciousness-raising groups, and serve internships supervised by feminists.

43.

Hare-Mustin, Rachel. Ethical considerations in the use of sexual contact in psychotherapy. *Psychotherapy: Theory, Research and Practice*, 11(4):308-310, 1974.

This article examines the use of intimate physical contact in therapy in light of ethical principles related to competency, community expectations, and the client relationship. Principal 2B of the *Ethical Standards of Psychogists* is quoted pertaining to boundaries of competency and use of techniques that fail to meet professional standards. The author questions how therapists can determine that sexual treatment is needed and that they are the most competent to provide such treatment. Hare-Mustin notes that training for therapists has not, to date, dealt with when and how to provide sexual contact or when such therapy is counterindicated. If, despite this, therapists deem themselves "competent" to offer sex as therapy, one must then ask whether this therapy is given to all patients who require it or just to young attractive ones of the opposite sex. Reference is made to Dahlberg's study of sexual contact between therapists and patients which reported that the only sexual contact that occurred was between older male therapists and women patients 10 to 25 years younger. Another principle from the *Ethical Standards of Psychologists* is quoted concerning the necessity of adhering to community norms. The author suggests that community standards regarding genital intercourse would be difficult to determine, but that community standards are generally more conservative for those in the healing profession than for the general public. She asserts that even the most liberal communities would be unwilling to accept arrangements involving payment for sex or making such sexual activity public by including it as part of licensed practice. A third ethical principle is quoted pertaining to the therapist's responsibility to inform potential patients in advance of any aspects of treatment that might affect their decision to take treatment. If genital intercourse is to be used in therapy, this should be clearly stated in advance to give the client the option of rejecting it before therapy begins. Additionally, the author notes that Masters and Johnson have discouraged transference in their treatment of sexual problems. She concludes that if ethical principles relating to competency, community standards, and the client relationship are used as guidelines, genital contact with patients in therapy is ethically unacceptable.

44

Lerman, Hannah. Some thoughts on cross-gender psychotherapy. *Psychotherapy: Theory, Research and Practice* (in press).

This article deals with the issue of male therapist-female client interaction in cross-gender psychotherapy that has been focused on by the women's movement. A 1975 American Psychological Association Task Force report on sex bias is cited. The report identifies four types of sexist behavior toward women clients:

(1) fostering traditional sex roles in women clients, (2) exhibiting bias in expectations of women, (3) sexist use of psychoanalytic theory, and (4) responding to women as sex objects. The author notes that data reveal sexual exploitation of women by their male psychotherapists to be much more prevalent than the profession wants to acknowledge. She suggests that even if this were the only form of sexism found, it would still raise serious questions about the predominance of the male therapist-female client dyad. More women are presently choosing to see female therapists, because of pressure from the women's movement as well as the fact that more women therapists are identifying themselves as feminist therapists. Consequently, the issue of whether women should see male therapists has, at one level, become an economic one. Despite the economics, the author asserts that the clear abuses of cross-gender therapy cannot be ignored and that present social circumstances require women in therapy to have female role models. Lerman suggests that if male therapists accept the premise that sexism is detrimental, they may find they can be of great value to male clients. They can share their special male awareness and explore with male clients the problems men have expressing emotionality to each other. Time can also be devoted to the sex-role issues that restrict men's growth as well as women's. The author concludes that both sexes will have to work separately until they reach a point of awareness at which they can join together. When all therapists have come to understand the influence of gender on modes of functioning, then therapist selection can be on the basis of individual characteristics rather than gender.

45.

Levine, Saul V.; Kamin, Louisa E.; and Levine, Eleanor Lee. Sexism and psychiatry. *American Journal of Orthopsychiatry*, 44(3):327-336, 1974.

"Psychoanalytic Theory," the first section of this review of feminist criticism of psychiatry, focuses on Freudian theory, which considers women to be biologically inferior and to possess negative character traits basic to their "nature." The theory shows no awareness of the importance of social conditioning and culture on character formation. It is asserted that current arguments against Freudian theoretical assumptions must be dealt with honestly and that the foundations of psychoanalysis may have to be reexamined. The authors further suggest that differences between the sexes need not mean inequality. In "Mental Health Statistics," the second area of criticism presented, statistics are cited showing that women are far more likely to have mental disorders than men and that certain diagnoses such as affective psychoses and schizophrenia have virtually become feminine disorders. The suggestions made for interpreting these figures range from the concept that adult women are inherently weaker and sicker than men to the idea that the mental health establishment fosters the subjugation of women by the nature of its operation. The authors point out in the third section, "The Practice of Psychotherapy," that 90 percent of the psychiatrists in North America are men and that psychiatry is a patriarchal system. They present criticism of psychotherapy as authoritarian and as merely helping people to cope with untenable situations. Additionally, they cite criticism of the institution as resembling middle-class marriage and the Broverman et al. study (1970) depicting clinicians' sex-role stereotypes for mental health as essentially a restatement of Freud's view of women. The final area of criticism concentrates on the "Psychological Effects of Sex-Role Stereotypes." The authors suggest that a sense of inferiority is not basic to female biology but is conditioned in women from earliest childhood. Rigid stereotypes for the female role have been documented and substantiated many times, and these stereotypes as reflected in child rearing and societal demands predispose women to destructive behavior patterns and emotional problems. Although there are constitutional differences between men and women, these are complicated by cultural conditioning. The authors feel psychiatrists must ask themselves if they are perpetuating the differences between society's haves and have-nots and if they are being used as agents of the state to prevent deviance from the established norms. According to the authors, those who deviate from society's mainstream and stereotyped roles are often labeled sick and locked away in mental hospitals. Ironically, even though women may be judged "sick" for not conforming to society's stereotype of feminine behavior, the traditional role of women as it was established in Freud's day has become largely obsolete. The alienation felt by women should not be equated with disturbance. The authors believe that theory and treatment must be reassessed in line with empirical data and that psychiatrists, because of the psychological consequences of oppression, should be in the forefront of the struggle for liberation and equality of the sexes.

46.

Miller, Nadine. Letter to her psychiatrist. In: Agel, Jerome, ed. *The Radical Therapist*. New York: Ballantine, 1971. p. 139-143.

This letter was written by Miller to her psychiatrist in June 1970 to explain her reasons for stopping therapy with him. She writes that there were always things that could not be said between them and that she distrusted him because of his sex, his position of privilege, and his inevitable prejudices. Now she regards therapy as an enforcer of women's dependency on men; women are led to believe they have problems rather than to realize they cannot function as human beings within society's oppressive "male supremacist" structure. By joining women's liberation, she has learned that her problems are not unique, but political, and that she has a valid basis for her hostility toward men, which the therapist had identified as a sign of illness. Miller deplores his failure to realize that there are alternatives to marriage that might bring fulfillment; she recalls that he defined her idea of joining a collective as an "escape." Miller has come to believe that psychiatrists want women to think they are crazy rather than oppressed in order to maintain the status quo. The only solution for her, she concludes, is unity with other women. She no longer cares if her psychiatrist calls her crazy—as he always did in the past whenever she acted in her own best interest.

47.

Mintz, Elizabeth E. What do we owe today's woman? *International Journal of Group Psychotherapy*, 24(3):273-280, 1974.

In this article Mintz reports, on the basis of her own experiences and those of her colleagues, that the assumptions made about women and their natural passivity when she received her training 20 years ago continue to be very much alive. She presents examples from various therapy groups that reveal an unthinking application of sex-role stereotypes. The lack of material dealing with different approaches to male and female patients in the group therapy literature is seen as an indication of the unwillingness of therapists to explore how assumed sexual differences affect therapeutic actions. If the goals of therapy are personal growth and movement toward self-actualization rather than mere symptom alleviation, assumptions about what is natural for women must be examined. Several of these assumptions that have been made by many group therapists are enumerated. According to Mintz, therapists must realize how their interactions with groups are influenced by such assumptions—be they valid or invalid—so that they can understand how these perceptions may be meeting their own personal needs. Warnings are given that women's liberation may be used to rationalize problems or to create guilt in women who choose traditional roles, and therapists are cautioned to be careful not to dismiss what may be deep-rooted problems as mere response to social pressure. Mintz credits the women's liberation movement with having freed men and women to express themselves more honestly in group situations and concludes that this very freeing of both sexes from stereotypes should be viewed as one of the tasks of group therapy.

48.

Rawlings, Edna I., and Carter, Dianne K. Unilateral and reciprocal influence in psychotherapy. In: Rawlings, Edna I., and Carter, Dianne K., eds. ***Psychotherapy for Women: Treatment Toward Equality.*** **Springfield, Ill.: Charles C Thomas, Publisher, 1977. pp. 34-45.**

The authors' thesis is that therapy, as practiced, differs from the theories espoused by psychotherapists and parallels Argyris' (1975) Model 1. Model 1, a general theoretical model that describes how people actually behave, is discussed and is summarized in tabular form. The influencing agent in Model 1 is "unilateral control." Therapy is seen as a closed system in which hypotheses generated by therapists become self-sealing, self-fulfilling prophecies. Success can be judged within the model, but there are no means to evaluate the values that are implicit in the situation. Although there are many schools of psychotherapy, the authors contend that they are more similar than different—with manipulation being the most important similarity. The authors assert that it is naive and perhaps irresponsible for psychotherapists to deny that they control behavior. They note that general descriptions of how manipulation occurs embrace all schools of psychotherapy and cite studies of psychotherapy as social influence. The two major sources of therapists' power are command and friendship, which are said to create the "placebo effect," an essential ingredient in all therapy. Creating cognitive dissonance is also discussed as an effective strategy of all therapies. Techniques used in therapies for making new beliefs and values resistant to change are presented. Rawlings and Carter maintain that therapists' techniques of social influence resemble the governing variables set forth in Model 1; therapists exercise "unilateral control" just like the agent in Model 1. Unilateral control is portrayed as completely incompatible with feminist values, and many women are reported to be enraged at their treatment by therapists who operate in the context of Model 1. A new model of reciprocal influence posited by Argyris as Model 2 is summarized in a second table. Presented as the best safeguard against the misuse of influence, the model has as its governing variables valid information, free and informed choice, and internal commitment. According to the authors, this system, in allowing for new information and open confrontations and testing, parallels the strategies of feminist therapy.

49.

Rawlings, Edna I., and Carter, Dianne K. Values and value change in psychotherapy. In: Rawlings, Edna I., and Carter, Dianne K., eds. *Psychotherapy for Women: Treatment Toward Equality.* Springfield, Ill.: Charles C Thomas, Publisher, 1977. pp. 5-33.

Rawlings and Carter describe the sources of therapists' personal and professional values and how these values affect the treatment of women. After establishing that therapy is concerned with changing client values and that value-free psychotherapy is not possible, the authors examine studies concerning the attitudes of men and women of different personality types toward woman's changing role in society. It is pointed out that certain types of people are extremely threatened by this change. On the basis of clinical evidence that a therapist's personality affects treatment, the authors identify therapists who, because of certain personality conflicts, could not be expected to provide effective therapy for women. Other sources of psychotherapists' values about women are the personality theories they adopt and their models of psychopathology and mental health. Biological determinism is explored, with special attention to the theories of Freud. According to the authors, believers in Freud's psychology of women, a theory that portrays women as innately inferior, could be expected to perceive women who fail to express their natural inferiority and submissiveness as in need of help to accept their femininity. Sociocultural theories of personality are also discussed. Horney's and Thompson's contributions to revising the psychology of women within the psychoanalytic framework are noted, and the factors that contribute to the psychology of women based on social-psychological formulations about the effects of prejudice on minority groups are explored. A "Summary of Ego Defenses" (adapted from Allport) illustrating the defensive behaviors women exhibit is presented in tabular form. Behaviors defined as feminine are shown as resulting from women's oppression and minority status rather than being innate. Therapists who hold a sociocultural theory of personality are portrayed as viewing women's inferiority as socially caused and correctible. Their therapeutic goals would be to enable women to develop their full human potential. The mental illness model of psychopathology, which places behavior problems in a medical analogue and ignores the social context, is also examined. The authors identify this model as legitimizing and reinforcing the existing power structure. They believe its implications are especially dangerous for women. Therapy based on an environmental model of pathology—personal problems result from social problems—is presented as designed to help the individual function as a responsible and active person rather than as a powerless victim. Pointing out that mental health professionals do not necessarily have a clear concept of what constitutes mental health, the authors examine three models of mental health. The normative model defines mental health as behavior that is compatible with the values and role prescriptions of society. This widely accepted model adheres to a double standard of mental health; adjustment to prescribed sex roles is its therapeutic goal. The authors discuss the difficulties this model creates for women who want to function as healthy adults. In the androcentric model, the male standard forms the basis for mental health. Feminists reject this model in favor of the androgynous model, which suggests that associating specific traits with particular sex roles constricts one's view of human nature. The treatment goals of the androgynous model of mental health would integrate the best of male- and female-associated characteristics, according to the authors.

50.

Rice, Joy K., and Rice, David G. Implications of the women's liberation movement for psychotherapy. ***American Journal of Psychiatry*, 130(2):191-196, 1973.**

In this article directed to psychotherapists, the authors present a four-part critique of psychotherapy along with implications for necessary change. They attempt to clarify the modifications that may be required in order to accommodate the changing views and attitudes created by the women's liberation movement. The first section deals with the antifeminine nature of the Freudian position. The authors indicate that many women may reject psychotherapy because of Freud's disparaging view of women. Although women have been working together to solve their own problems, there are some emotional problems that require the skill of a trained therapist. Therefore, the authors suggest, as a preferable alternative, an emphasis on the modifiability of Freudian theory and a willingness on the part of Freudian-oriented and other therapists to redefine their theories of female sexuality and role behavior. The predominance of male therapists is a problem, since the perceived inability of male therapists to understand their female patients is likely to be increased because of the shifting roles and expectations the women's movement has created. Hostile feelings toward men also have emerged; this hostility must be acknowledged so that it can be expressed and worked through during therapy. The third problem area in psychotherapy is the tendency of therapists to view role unhappiness and the rejection of traditional behavior as pathological. Most therapists fail to deal with the social context that creates a kind of "schizophrenia in women." The authors give examples of how the culture places near impossible demands on women, demands that create low self-esteem and loss of identity. Women are overtly taught to love themselves and their feminine roles, while covertly the culture shows them they are inferior and loathsome. The authors point out that role questioning is a healthy rather than a pathological process and that therapists would be more helpful if they assisted their patients in exploring new roles and models. As the fourth critical item, the authors contend that the women's movement threatens the power of the psychotherapist with its demand for equality. They advise the therapist to reevaluate his role and become an active participant in a therapeutic process that acknowledges the new values and social trends. The authors identify several implications for training that have grown out of the women's movement: the need for therapists to be trained specifically in the psychology of women and to participate in sensitivity training to discover their own sexual expectations and role bias; the need for therapists to be trained to serve as active proponents of alternative lifestyles and to work in the community for social change; and the need for more female therapists to be trained, but trained in nonsexist attitudes. In discussing alternatives to traditional treatment methods, the authors recommend the increased use of couple or group therapy with male and female cotherapists. They also advise therapists to recognize the value of alternatives to psychotherapy, such as consciousness-raising groups, in assisting the many women patients faced with problems created by the current change in roles.

51.

Seeman, Mary V. Critical evaluations. "Modern Woman: Implications for Psychotherapy." II. Woman's adjustment to being modern. ***Canadian Psychiatric Association Journal*** **(Ottawa), 18(1):84-85, 1973.**

Seeman, in her criticism of Stephenson's article ("Modern Woman: Implications for Psychotherapy"*), disagrees with some of Stephenson's conclusions about psychiatric tenets. She defends mother-child symbiosis as a fact of mammalian existence instead of the cultural phenomenon Stephenson considers it to be. The concept of penis-envy is also defended as based on actual observations of children. She suggests that envy is not necessarily destructive and can serve as a motive force leading to achievement. Seeman warns that therapists should not lose track of "valid" truths, such as woman's internal instincts, in their scrutinies of sex-role bias. She comments that therapists might do well to use the attitudes and techniques of adolescent psychiatry in dealing with "role-questioning" women who are going through crises similar to those of adolescence. She asserts that adjusting to society's norms was never a goal of psychotherapy as Stephenson claims and goes on to suggest that healthy living could be regarded as "the art of applied adjustment," if it is remembered that there are options other than adjusting. Seeman concludes by pointing out the many adjustments the "New Woman" has to learn to make to integrate new desires with old instincts so that she can make changes in her environment that increase her possibilities for self-fulfillment.

52.

Shainess, Natalie. The equitable therapy of women in psychoanalysis. In: Rawlings, Edna I., and Carter, Dianne K., eds. ***Psychotherapy for Women: Treatment Toward Equality.*** **Springfield, Ill.: Charles C Thomas, Publisher, 1977. pp. 104-119.**

Shainess establishes that women are the largest "minority" group in terms of lack of power and notes that the history of discrimination against women has contributed to today's therapeutic prejudice against them. According to her definition, good therapy is appropriate to the individual needing help, requires a clear understanding of symptomatology, offers the most economic help in terms of energy, effort, and money, and imposes as little as possible from without. She asserts that good therapy for women must incorporate Harry Stack Sullivan's (1953) theory that mastery leads to euphoria while incompetence creates anxiety. Many sources are cited to establish the prejudice of therapists in relation to women. Shainess regards assertion as the key to the proper interpretations of a female patient's behavior. She aggrees with Jakubowski-Spector (1973) that women need help to be self-assertive so that they can master their own lives and develop new belief systems to counteract the irrational guilt that taking assertive action creates in them. Emphasizing the political nature of psychiatric practice, Shainess notes that women have been cast in a powerless neurotic-dependent personality type and that self-assertion may cause greater anxiety than the anxiety created by their arrested growth. Giving examples of the ways women are excluded from societal interaction, Shainess suggests that therapists must be attuned to the nuances in the linguistics of social interaction. She identifies the gender-related aggressions committed in communications as crucial and not often understood by male analysts. Without this sensitivity to the subtleties of communication, therapists will not be able to help women become self-assertive without guilt. In a brief discussion of tenets relating to women's sexual and reproductive role, Shainess discusses abortion. Noting that many analysts consider woman's response to abortion to be bioinstinctual and assume guilt will accompany abortion, Shainess indicates that guilt and ambivalence seem to be disappearing now that societal attitudes toward abortion have changed. She discusses sexual issues and expresses her belief that women can only become uninhibited and capable of free sexual activity when they gain a sense of self and the capacity for self-assertion. Identifying honesty and authenticity as vital to greater satisfaction in sexual relations, she indicates that therapists must stress these qualities. Shainess concludes that the problems of women and their treatment are two-fold—those connected with being women (as abortion and sexual issues) and those connected with their long history of powerlessness and subservience. A therapist who wants to help women must empathize with their need to express themselves through new roles and must "get away from the trite, unfeeling, routinized effort that has passed as therapy."

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*Abstract of article included in this bibliography.

53.

Steinmann, Anne. Sex role biases in psychotherapy. *International Mental Health Research Newsletter*, 15(2):8-12, 1973.

In this article the author relates her research on sex roles to the topic of sex-role bias in psychotherapy. A brief review of her 20 years of research is included. Steinmann indicates that this culture produces many frustrated and confused women; sex-role stereotypes block them from the achievement outside of home and family life that their education seemed to promise them. When women are forced to give up their career plans and settle for only half of their ambition—that half that was oriented around their traditional sex role—they feel unfulfilled and often seek psychotherapy. Their complaints center around identity and role-confusion. The author asserts that these women can only be helped by therapists who are free from sex-role bias. The Broverman et al. study is cited to suggest that therapists do tend to reinforce society's sex stereotypes. However, Steinmann takes issue with the idea that therapists discriminate against women on the basis of their Freudian or non-Freudian training. She suggests, instead, that clinicians who discriminate against women are individuals who have not been fully analyzed and fail to understand their own projections. Steinmann then deals with the issue of the misinterpretation of many of Freud's concepts. She reviews the biological basis of psychoanalysis and presents the stages of psychosexual development in women as theorized by Freud and modified by Bonaparte and Deutsch. Steinmann emphasizes Freud's understanding that many masculine traits were present in women, and she asserts that all Freudian therapists stress the necessity for women to realize their masculine potential. Freud is also defended against the accusation that he had a negative attitude toward women. Steinmann points out that a therapist who exhibits bias, or uses his unresolved hang-ups on sex roles to influence therapy, may appeal to an authority like Freud to defend his prejudices. The author cites her own clinical experience that many women have poor self-concepts and feelings of inadequacy as a result of stereotypes and discriminatory practices. She maintains that therapists who reject the idea that a woman is a person with masculine as well as feminine attributes only add to the confusion. Two cases are presented from the author's practice; these illustrate the sex-role bias two women experienced in psychotherapy before coming to the author. Steinmann describes her efforts to counteract the discrimination and to help the women fulfill themselves. In conclusion she identifies ways in which therapists can avoid the kind of discrimination illustrated: continual examination of their own sex-role hang-ups; conjoint therapy with a therapist of the opposite sex; dedication to the belief that empathy is possible; and recognition that sex-role bias can also be present with people of the same sex.

54.

Stephenson, P. Susan. Modern woman: Implications for psychotherapy. *Canadian Psychiatric Association Journal.* **(Ottawa), 18(1):79-82, 1973.**

Stephenson views the New Feminism as having important implications for psychiatric theory and for psychotherapy. Psychiatrists are now being criticized for their contribution to the female role stereotype, their failure to comprehend change, and their tendency to advise women to conform to the acceptable feminine role. Background information is presented on psychiatry's tendency to prolong the assumptions and values that maintain women as inferior beings. References are made to the theories of Freud, Adler, Bowlby, and Spitz along with Friedan's concept of the rise of the "feminine mystique." Noting the destructive implications of the female stereotype, Stephenson maintains that women suffer from prejudice like members of any minority group. The work of Broverman et al. on the different standards mental health clinicians have for men and women and the difficulties these dual standards create for women are described. The author suggests that the "empty nest syndrome" stems from the notion that childbearing is woman's most creative function. Furthermore, marriage is seen as a condition of risk for women, since middle-aged unmarried women have been found to be the group most free from mental illness. The author points out that recent changes in society have particularly affected women—there are shifts in attitudes related to marriage, family, and sex roles. As feminism has become increasingly popular, women have come to realize that many of their "unique" problems are actually part of a general cultural malaise. Indicating that feminist literature has a tendency to overgeneralize, the author maintains that many feminist arguments apply only to middle- or upper-class educated women. She notes that most differences between men and women are learned and that women's emotional discomfort comes largely from their role assignment, their worries about behaving in a "masculine" way, and guilt about defying traditional values. Stephenson concludes that therapists must examine their own attitudes about sex-role stereotypes, make sure that they are not reinforcing social and intrapsychic conflict, and guard against an "adjustment" notion of mental health. She recommends that the best course for women who voice dissatisfaction with their traditional role may be referral to a women's liberation group or to a couple's group where common concerns can be shared.

55.

Szyrynski, Victor. Critical evaluations. "Modern Woman: Implications for Psychotherapy." III. The therapist's attitudes and values. *Canadian Psychiatric Association Journal* (Ottawa), 18(1): 85-86, 1973.

Szyrynski discusses the questions raised in Stephenson's article ("Modern Woman: Implications for Psychotherapy"*) concerning the influence of a therapist's social values and adherence to certain social stereotypes on therapy. Szyrynski notes that many women are asking their therapists for assistance in identifying their life goals and formulating their life philosophy. To respond to this need, he suggests that therapists will have to identify the goal of psychotherapy. In attempting to increase the patient's ego strength, the psychotherapist will need to "follow" the patient in her struggle with conflicting social values. The patient will require help to accept her own human dignity, but, such acceptance will free her from nonauthentic social pressures and enable her to face issues maturely. Because all people are different, clinicians must be careful not to enforce any particular social pattern nor to think of people on the basis of rigid social stereotypes. Szyrynski concludes that Stephenson should have more extensively examined the issues she raised from the perspective of woman's contemporary position and its impact on the psychotherapeutic process.

56.

Taylor, Barbie J., and Wagner, Nathaniel N. Sex between therapists and clients: A review and analysis. *Professional Psychology*, 7(4):593-601, 1976.

In this review article, Taylor and Wagner point out that within the nature of the psychotherapeutic relationship, it is not unusual for sexual attraction to occur between therapist and client. This attraction can be an effective therapeutic tool, but, when acted upon, sexual contact has definite impact on the therapeutic process. The authors found 34 cases of therapist-patient sexual contact in their survey of the literature and rated outcome on the basis of the material presented in the case history or the patient's rating of the involvement. Twenty-one percent of the relationships were judged to have positive outcomes, 32 percent mixed outcomes, and 47 percent negative outcomes. The authors suggest that the literature presents only a fraction of the actual number of these sexual contacts, since therapists are often unwilling even to discuss the issue. Citing several authors, they point out that it is common to discuss the sexual feelings and needs of the patient and therapist in terms of transference phenomena. What is "real" and what is "transference" in a relationship is, however, difficult to determine. Kardener's (1974) concern that a sexual relationship between therapist and client resembles incest and the problem of a lover/therapist's inability to maintain appropriate therapeutic objectivity are discussed. Seagull's (1972) work on the specific "issues of technique" raised by sexual contact is also presented. The altruistic nature of these contacts is questioned, since the vast majority involve a male therapist and younger female clients. Attention is also given to the issue of the sexual skill of the therapist and to legal problems that have arisen. The authors suggest that the unequal nature of the power distribution in therapist-client relationships makes it unfair for a therapist to turn the relationship into a sexual one. Alternative approaches to direct sexual contacts for clients with specific sexual dysfunction are suggested. In situations where there is no presented sexual dysfunction but mutual attraction exists, the authors recommend that the implications of a sexual relationship be fully discussed. If a sexual liaison is formed, therapy should be terminated, with the understanding that the sexual relationship is not a taboo subject with any new therapist. Fantasies and expectations must be discussed thoroughly because of the godlike position the therapist may hold. To prevent a gradual seduction into sexual contact, sexual attraction can be acknowledged and used for therapeutic purposes. The authors conclude that the large potential for harm in therapist-client sexual contact makes risking it unwise. If sexual activity is indulged in, it should be done so as honestly as possible and the therapeutic relationship should be immediately terminated.

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*Abstract of article included in this bibliography.

57.

Tennov, Dorothy. Feminism, psychotherapy and professionalism. ***Journal of Contemporary Psychotherapy*, 5(2):107-111, 1973.**

Originally presented at a feminist psychology conference in 1972, this paper deals with the conflicts between the concept of Sisterhood and the concepts of psychotherapy and professionalism. Tennov defines Sisterhood as a conscious and loving process of turning away from the traditionally competitive nature of relationships between women, whereas psychotherapy is described as the "unproven and expensive tyranny" of one person over another. She notes that the unequal relationship inherent to psychotherapy is often detrimental and always disrespectful. Professionalism is defined as the "banding together in mutual self-protection of an in-group which has managed to gain a monopoly over some kind of service or technique." Tennov considers the two greatest current professional oppressors to be Medicine and Law. Psychotherapists who are members of the medical in-group are far more powerful than other therapists, although nonmedical therapists are working to professionalize themselves. Tennov asserts that Sisterhood and psychotherapy are completely incompatible and that one cannot be a psychotherapist and a feminist at the same time. The techniques of psychotherapy are at best "unproven," but they offer many rewards to the practitioner. Viewing psychotherapy as exploitative by the nature of its professionalism, Tennov urges women to forsake the gratification of being therapists for the cause of Sisterhood. Self-help, or the bypassing of professional assistance, is held compatible with feminism and Sisterhood. Furthermore, the author points out that many self-help programs have succeeded where professionals have failed—citing examples such as the Los Angeles Women's Health Center and the Day Top and Synanon drug programs. One of the chief advantages of the self-help program is that financial interests do not compete with the provision of needed services. Tennov concludes by responding to six questions that conference organizers asked about feminism and therapy—concepts she regards as in opposition to each other. Answering a question, she says she would like to see the formation of a feminist therapy that is scientific in its method and based on a model of equality.

58.

Tennov, Dorothy. *Psychotherapy: The Hazardous Cure.* New York: Abelard-Schuman, 1975. 314 pp. (Paperback edition: Garden City, N.Y.: Anchor Books, 1976. 339 pp.)

In this documented critique, Tennov's focus is on the specific dangers of psychotherapy for women. Most women in treatment are reported not to be "mentally ill" but, in fact, particularly affected by the "woman's situation." In the seven chapters of this book, the material presented concentrates on the actual psychodynamic psychotherapy experience, psychotherapy and scientific research, somato-psychic illness, professionalism, the current variety of help approaches, women and the psychotherapy professions, and alternatives to psychodynamic insight therapy. The author points out that psychodynamic psychotherapy holds the individual responsible for problems and fails to recognize societal contributions. In addition to promoting social control by the therapy process itself, the psychodynamic approach, by directing the individual's attention inward, reduces the likelihood of involvement in efforts to change society. The women's movement is actively fighting the theory that problems are personal neuroses; it identifies, instead, the sex caste system as responsible for many individual difficulties. A review of Eysenck's (1952) research challenging the effectiveness of therapy is presented, and the negative response to this and other experimental research among the psychotherapy community is documented. In discussing the current professional scene and its profusion, Tennov notes that psychotherapists continue to be involved in protecting their profession, deemphasizing or ignoring the social factors that contribute to individual problems. Moreover, they work with no real regulatory function and essentially without accountability. She identifies the need for consultants whose approach is not psychodynamic, who consider the external environment and the social conditions, and who examine behavior for solutions and explanations. Accordingly, Tennov recommends the use of behaviorist methods, although she recognizes that such methods do not guarantee that the clinician is without bias or that this will not affect the persons seeking help. When therapeutic goals and procedures are clearly specified, as in behavior therapy, however, the client at least has the opportunity to evaluate whether the procedure is effective—in marked contrast to her counterpart involved in insight therapy.

59.

Weisstein, Naomi. "Kinde, Kuche, Kirche" as scientific law: Psychology constructs the female. In: Morgan, Robin, ed. *Sisterhood Is Powerful: An Anthology of Writings from the Women's Liberation Movement.* New York: Vintage Books, 1970. pp. 205-220.

Weisstein documents psychology's inability to describe what "liberation" for women would mean and what the limits of human potential are. Quotations from several prominent male psychologists on the nature of women reveal a fairly general consensus that "liberation for women will consist first in their attractiveness, so that second, they may obtain the kinds of homes, and the kinds of men, which will allow joyful altruism and nurturance." The author identifies psychologists' attitudes as compatible with the general prejudice in society concerning the nature of women. She argues that psychologists have no idea what women are like or what they need or want because their discipline has failed to understand why people act as they do and what would make them behave differently. Clinicians and psychiatrists fail to understand because they rely on untested theories and because they deal with personality in terms of inner traits rather than in the social context. In the tradition of Freud, clinicians base their conclusions on clinical experiences—a reasonable approach to developing but not validating theories. Indicating that psychology is scientifically unsound, Weisstein cites long-accepted theories that have been proven entirely false by recent scientific testing. She further asserts clinical experience can serve to reinforce biases and cannot be considered as comparable to empirical evidence. A 1952 study by Eysenck, described as yet unrefuted and many times confirmed, is cited as challenging the idea that psychotherapy is even efficacious. Thus, clinicians and psychiatrists can justify their work only by ignoring these data and by not conducting any outcome-of-therapy studies. Their theories about women are no more valid than the unsubstantiated clinical theoretical framework of which they are a part. Yet, even if psychologists developed the means for rigorous testing, Weisstein asserts that full understanding of behavior would continue to elude them unless their individual orientation were abandoned and the social context were also evaluated. Weisstein presents data showing that even in supposedly objective testing situations, subjects perform according to testers' expectations, and thus the biases of the testers influence results. The social expectations for women must be understood before their behavior can be characterized; women do not exist in a vacuum. Currently, the characteristics of women in our culture are equivalent to the typical minority group stereotype of inferiority. Weisstein concludes that the limits of human, or female, potential cannot be defined until psychologists realize they are limiting this potential with their expectations and inability to recognize that people do not exist apart from their environment.

Sexism in Other Treatment

60.

Fidell, Linda S. Put her down on drugs: Prescribed drug usage in women. Paper presented at the Western Psychological Association Meeting, Anaheim, Calif., April 12, 1973. (Source: Know, Inc., P.O. Box 86031, Pittsburgh, Pa. 15221)

This article examines how sex stereotyping in medical practice contributes to women receiving a disproportionately large number of prescriptions, especially for psychoactive drugs. Although there is little information available concerning the factors that lead women to obtain and use drugs, Fidell suggests that doctors may prescribe more psychoactive drugs because of the type of interactions that occur between them and their female patients. The author cites Zola's (1966) study describing the different reactions of physicians to stoic Irish patients and expressive, emotional Italian patients who were matched for seriousness of illness. The Irish patients, whose behavior was similar to the expectations for men in this society, were diagnosed as being more urgently in need of medical attention than the Italians who behave medically as women do. Based on this study and the fact that men are more likely to present purely physiological symptoms than women, Fidell speculates that physicians are more likely to send women away with mood-modifying drugs. Citing research and making reference to sex-role stereotypes physicians learned in medical school, Fidell indicates that physicians with more pessimistic attitudes about treatment outcome are more likely to prescribe drugs that alter the psyche rather than treat physiological symptoms. Physicians may more readily prescribe tranquilizers for women, because they feel women need not be as mentally alert as men and because they hold the same pessimistic view about women's role in this culture that is held by many women. Drug company advertising that confirms sex stereotypes and associates psychoactive drugs with women and nonpsychoactive drugs with men is explored as another contributing factor to the phenomenon. Fidell concludes that women and men receive differential treatment in the medical setting and that these differences do not work in the best interest of women.

61.

Fine, Paula. Women and shock treatment. *Issues in Radical Therapy*, 11(3):9-11, 1974.

Fine raises questions about electric convulsive therapy (ECT) and its much more frequent use with women than with men. The article is based on research about the effects of ECT and observations made in the author's work at a mental institution where the majority of women diagnosed as depressed, hysterical, psychotic, and schizophrenic were treated with ECT. Although ECT was first introduced in 1938, there is still no agreement on how it actually works. One theory maintains that ECT induces amnesia and that its recipients learn to banish future stressful experiences from memory. Questioning the desirability of amnesia, Fine discusses the use of ECT in two groups of women: those whose traditional role has created a loss of self-esteem leading to depression and those who are experiencing the "empty nest" syndrome. ECT's effects prevent these women from questioning their feelings of diminished worth and ultimately from concluding that these feelings are not unfounded. The author notes that women treated with ECT are often frustrated by their amnesia and still do not know why they feel depressed, although they may admit to it more readily after ECT. A second theory about ECT is that it gives the patient a jolt that makes her face reality. This, however, contradicts the amnesia theory, and it is indicated that many women identify ECT as a punishment. The author points out the many dangers in the use of ECT. It often leaves people more fearful and confused and increases stress, which can cause resistance to therapy and loss of identity. Therapy may begin with a woman unsure of her identity and end with the same woman unable to feel or remember any identity at all. Fine suggests that ECT is sometimes used to shut women up and stop their complaints. In her own experience, women often underwent treatment because they were failing to do what they were supposed to do and because the hospital program's goal was to encourage traditional sex roles and socially desirable behavior. Fine cites reasons suggested by Dr. Robert Morgan for the continued use of ECT despite its lack of efficacy for many patients and the proven risk of associated brain and psychological damage. She also reports on a 1973 study conducted in the Department of Psychiatry at the University of Rochester Medical Center, which showed that 72 percent of the 276 patients who received ECT were women; no explanation was given for this difference. Additionally, she reports that 6 months of records at the mental hospital where she works revealed that considerably more women than men receive ECT. Fine concludes by reiterating many of the questions raised in her article and by suggesting that the overuse of ECT will continue unless collective action is taken by women to gain control over their lives.

62.

Harris, Ann. The Tori model of change and the changing woman. *Training and Development Journal*, 29(8):22-27, 1975.

Harris analyzes the effectiveness of the TORI method, a type of personal growth/sensitivity group, in helping women deal with change and grow toward their full human potential. The report is based on her experience at a TORI weekend and on published theory by TORI's originator, Jack Gibb. TORI is a specific group method that provides minimal structure, low profile leadership, and lasts for a set period of time. Harris suggests that two dynamics held her seemingly unstructured TORI weekend together: (1) the fact that joining with others for the experience was identified as responding to common needs for personal meaning and a sense of interpersonal connectedness; and (2) the strong set of group norms that were operative around the experience. The norms were "Everyone is free"; "Roles and intellectualizing are defenses which block interdependent or interpersonal communication"; and "Each person is responsible for what happens to her/him." These norms were established before the workshop began in the material sent to participants, and they were reinforced during the weekend. The goals and assumptions that operate in the TORI model, based on a humanistic frame of reference, are explained. Harris contends that TORI fails to respond to the female experience or provide help for the effects of sexism on women. By not acknowledging the impact of sexism, TORI is merely treating symptoms and furthering the disease. Each one of TORI's norms is examined to reveal inaccuracies concerning the condition of women. While all the people involved in the weekend were urged to eliminate their outside roles, Harris reports that male-female roles continued in their traditional way. The influence of sex roles was not acknowledged despite the fact that sex-role issues were obvious in many group activities. Harris believes that TORI's emphasis on the norm of individual responsibility reinforces cultural sexism because it denies the reality of women's oppression and attributes feelings of inferiority to personal neurosis. Harris maintains that TORI provides no stimulus for change in women; it misses women's core identity problem and merely confirms traditional sex roles. She also takes issue with the way TORI proposes anarchy as the community structure and functions as if this ideal were a fact. Until sexism is made conscious and resolved, asserts Harris, no community of equals can exist. TORI is viewed as delivering the "Tyranny of Reinforced Inferiority" to women—instead of the trust, openness, realization, and interdependence it aspires to and may indeed offer to men. Harris proposes that change points be explored so that alternatives, such as TORI, can apply to women as well as men. A clearer psychological foundation and identification of women's need differences would make it possible to create programs that could help women work toward self-actualization. Suggestions are offered for temporary solutions within existing programs until this is accomplished.

63.

Howard, Ephraim M., and Howard, Joyce L. Women in institutions: Treatment in prisons and mental hospitals. In: Franks, Violet, and Burtle, Vasanti, eds. *Women in Therapy: New Psychotherapies for a Changing Society*. New York: Brunner/Mazel, 1974. pp. 357-382.

The authors present data from agencies controlling prisons and mental hospitals and from interviews with 53 inmates and former inmates in order to determine whether society's attitude toward women as a "semi-oppressed" minority was reflected in their treatment in these institutions. Little attention has been paid to women prisoners in penal literature. Generally, the treatment of women in prisons is patterned after that of men; it has not focused on meeting the needs of women. Although women are less likely than men to be homosexually assaulted by other prisoners, they face the risk of becoming sexual objects for the prison staff. Since most states have only one female prison, all women, whether first offenders or hardened recidivists, are placed in the same institutions. Education in prison is less available to women than to men largely because of the attitude that women offenders are children with short attention spans. Women are also neglected in the area of psychotherapy. Treatment was first tried in men's institutions and was only available to women if proven successful with the men. Men are allowed conjugal visits in most states, but women are not. Women are conditionally released more frequently than men but with more stringent conditions concerning employment and housing. The authors suggest that this may account for the fact that fewer women return to prison from their conditional releases than men. As for mental hospitals, aberrant behavior such as drunkenness, fighting, and leaving home are more likely to be considered cause for treatment in women than in men. On the basis of 1970 National Institute of Mental Health data, particularly information from general hospitals and community mental health centers, certain diagnostic categories seem to apply mainly to women. More of the women admitted to general hospitals are diagnosed as depressive than are men. The next highest diagnostic rating for women is for "other neuroses," followed by schizophrenia. The authors point out that the diagnostic label affects treatment, identifying electroshock therapy as the preferred treatment for the diagnoses of depression and schizophrenia. Men who become overactive or otherwise act out are given greater doses of medication. Women who "misbehaved" were more likely to receive electroshock treatments. Relying on interview data, the authors note that in such categories as education and skill training, recreation, therapy, and physical treatment, the treatment of men and women in mental hospitals generally seems to be similar. Inequities that occur in these areas appear to be the result of the policy of an individual institution or the behavior of a particular staff member. Men who are able to return to their families, and women who show a willingness to assume their usual responsibilities have similar release rates. However, if the patient requires special or family care, men are released more slowly than women; outpatient facilities are less available for men. The authors conclude that the differential treatment women receive in prisons and in mental hospitals is a reflection of the differential treatment of women by society. Although women may receive some advantageous differential treatment before institutionalization, once institutionalized, women experience many aspects of the system which are detrimental to their sense of worth and well-being as individuals. In both institutions their treatment is oriented toward producing the desired degree of social conformity.

64.

Kasten, Katherine. Toward a psychology of being: A masculine mystique. *Journal of Humanistic Psychology*, 12(2):23-43, 1972.

Using Maslow's book *Toward a Psychology of Being* as her primary source, Kasten explores the sexist views held by many mental health professionals who consider their orientation to be existential or humanistic. As a result of the new emphasis on individuality, actualization of human potential, and psychological growth, therapists are changing the way they relate to clients. The fundamental faith of this new existential psychology is that human beings have an innate drive to realize their full potential for being. According to Maslow, however, this drive is "weak and delicate and easily overcome by habit, cultural pressure and wrong attitudes toward it." Consequently, many people fail to fulfill their potential. This produces an anxiety, which Maslow labels the "intrinsic conscience"—a kind of self-condemnation for inability to move toward actualization. Kasten suggests that self-actualizing people must necessarily resist enculturation and become detached from their culture and society. Anger is identified as an important strength for self-actualization. Although theories on self-actualization would seem quite applicable to women's struggle against sex-role stereotypes, humanistic psychologists writing on the topic (Maslow, Rogers, May, Perls) have, in fact, failed to face the problem of sex-role stereotyping. Maslow's theories are discussed, and examples of their sexism are given. It is shown that real self-actualization and its risk-taking are equated with qualities identified as masculine. Problems arising from sex roles are only recognized as problems if they cause men discomfort. Maslow writes completely from a male point of view, considering femininity and masculinity as innate. He ignores or fails to see the impossibility of his ideal "being-love" when both men and women must conform to sex roles that make women inferior. In dealing with the problem of adjustment as a threat to mental health, he again ignores the problem of adjustment to sex roles, thereby giving those destructive sex roles his tacit approval. Kasten suggests that the sexism inherent in Maslow's work demonstrates that even the most contemporary humanists have incorporated sexist values into systems that would logically necessitate their rejection. Because therapists generally have a double standard of mental health (Broverman et al.), they tend to promote dependency in women. They want to protect them from the aloneness that comes from defying sex roles—the same aloneness that they identify as a normal part of self-actualization. More therapists, mostly women, are becoming aware of women's double-bind situation and view their anger as a healthy reaction to oppression. Even feminist therapy must not be regarded as an answer to women's problems, however, since it still involves an individualistic approach to social needs. Kasten asserts that political action will be necessary to change attitudes and open up new possibilities for

65.

Kaubin, Brenda J. Sexism shades the lives and treatment of female addicts. *Contemporary Drug Problems*, 3(4):471-484, 1974.

The invisibility of the female addict is one of her biggest problems according to this article. Despite the fact that women are quickly losing their "minority status" in the addict population, only statistical data are available on female addicts. Little work has been done which concentrates on who the female addict is and what her special problems are as a woman and as an addict. To learn how sexism adds to the female addicts' problems, Kaubin visited and interviewed key personnel in several treatment programs serving women addicts in the Philadelphia area. Exploring why so little research has focused on the female addict, she suggests that the stigma attached to the female addict is a factor in her absence from both the literature and treatment centers. Male addicts are more likely to be arrested for crimes and forced to take treatment, whereas female addicts are often protected and hidden in their homes where they are felt to be needed to care for their children. They are guilt-ridden about their addiction, and the things they have done because of their habit—such as prostitution and leaving their children. Many female addicts enter treatment with an attitude of self-hatred; they perceive themselves as sex objects for men and lack any positive relationships with other women. Often they are punished for sexually provocative behavior in treatment centers where such behavior is forbidden but may be covertly encouraged. When men and women are treated together, women often receive less attention, because they are less likely than men to be assertive concerning their needs. Additionally, they may be uncomfortable talking about their problems with men in a mixed group. The author reports that the male therapists at treatment centers often have difficulty dealing with female addicts who behave in an "unfeminine" manner, who express the anger that society doesn't allow women. She suggests that many of the problems confronting a female addict in treatment are related to sexism and sexual issues which may, additionally, have led to her addiction. Mood-altering drugs are often prescribed for women to keep them content with their lives—a practice that may, in fact, lead to addiction. Regarding women alcoholics, Kaubin asserts that their reasons for drinking differ from those of male alcoholics and that this factor must be considered in their treatment. She presents and discusses the program at the TODAY treatment center in Bucks County, Pa., and the beliefs of its director, Ardelle

Schultz. Schultz maintains that liberation from sex-role stereotypes may provide a large part of the answer for female addicts and suggests that the ideal treatment model would be sex-segregated residential facilities for early treatment, with the men and women mixed in later treatment and reentry programs. Kaubin concludes that more facilities are needed to treat female addicts and that the public must be educated to eliminate the stigma and taboo surrounding these women. She identifies sexist attitudes and practices as largely responsible for the failure to meet the needs of female addicts.

66.

Lennane, K. Jean, and Lennane, R. John. Alleged psychogenic disorders in women—A possible manifestation of sexual prejudice. *The New England Journal of Medicine*, 288(6):288-292, 1973.

It is not at all uncommon for physicians to prescribe treatment to relieve patients' symptoms, even when their cause is incompletely understood. This article suggests, however, that this is not the case for certain conditions—many of which affect only women. Four such conditions are the focus of concern in this article: dysmenorrhea, nausea of pregnancy, pain in labor, and infantile behavioral disorders. Although these conditions have physical manifestations, they are widely regarded as being psychogenic in origin. Primary dysmenorrhea occurs in about 50 percent of all women and has clearly been shown to be related to ovulation; yet this condition is treated as an emotional disorder. The authors present evidence to refute this position, and they suggest that the attitude toward treating dysmenorrhea may be unusual. Although suffering from symptoms that seem identical to those of any severe visceral colic, the dysmenorrhea patient—unlike the visceral colic patient—may be denied the relief of pain and the rest that she requires. Nausea during the early months of pregnancy is dealt with similarly, despite its occurrence in 75 to 88 percent of all pregnant women. The authors present evidence that nausea may be due to the heavy secretion of estrogen during pregnancy. They suggest that it is most unusual to classify up to 88 percent of the patients with the organic condition of pregnancy as neurotic because they suffer from nausea. Pain in labor is another problem that is dealt with in this same manner. Because physicians attribute labor pain to anxiety rather than to physiological causes, women are often denied medication that could help them in childbirth. Most physicians deal with colic in infants as a psychological disorder caused by maternal anxiety and conflicts, even though its causes are unknown, and the prevailing medical attitude is not supported by scientific studies. In all these cases the authors note the ready acceptance of a psychogenic origin without evidence, and the persistent and damaging nature of that belief. They suggest that the mechanism for reaching this conclusion in all these conditions is the reversal of a truism. The fact that physical disorders may well cause anxiety is reversed, and although the reversal is incorrect, it still seems to accurately describe the phenomena observed. Lennane and Lennane contend that an erroneous belief in psychogenesis is damaging to patients in many ways. They indicate that the prejudice inherent in this illogical persistence of damaging beliefs may well have an underlying sexual basis. From a practical point of view, however, they ask that this speculation not be allowed to cloud the central issue—the need for the application of normal objective scientific methods to these topics.

67.

Lerman, Hannah. A feminist view of the current practice of sexual therapy. Paper presented at the Western Regional meeting of the Society for the Scientific Study of Sex, San Diego, Calif., June 28-30, 1974.

Lerman asserts that even the innovative field of sexual therapy has not escaped the influence of society's sex-role stereotypes. Although myth breaking is a significant part of the scientific study of sexuality, sexual therapists have not felt compelled to review their own behavior as therapists and human beings. Male-female therapy teams are identified as functioning like traditional marriages and perpetuating the myth of male superiority. Male dominance in these teams generally stems from the man's superior credentials—credentials that a male-oriented social system has made it relatively easy for him to acquire. By allowing the male to dominate therapy, these teams perpetuate society's sexist attitudes by example. Lerman also deals with the issue of sexual surrogates, pointing out that only female surrogates create a problem, since the law and, reportedly, even male therapists have trouble distinguishing them from prostitutes. She maintains that sexism in sexual therapy is no different than in other fields, but, since sexual therapy claims to be innovative and enlightened, an effort at self-examination and at extending its liberality to social issues should be made. Lerman feels that sexual research has focused on the female response, because most of the research has been directed by men who believe their own sexuality is easily understandable. She suggests that the male sexual response might prove to be as complex as the female's if studied as extensively. Although Masters and Johnson established that women achieve more intense orgasms through masturbation, the focus of sex therapy continues to be on intercourse where the male orgasm is the main event. Noting that feminists have been critical of this male orientation, Lerman suggests that sex therapists must deal with other expressions of female sexuality. Some women sex therapists have been working with women without their partners so that the women can better explore and find themselves without the intrusion of the predominant male orientation. The author closes by saying that she is saddened by the fact that sex therapists have no more examined their attitudes toward women than has the rest of society.

68.

Levy, Stephen J., and Broudy, Marie. Sex role differences in the therapeutic community: Moving from sexism to androgyny. *Journal of Psychedelic Drugs,* 7(3):291-297, 1975.

The authors define the concepts "sexism" and "androgyny," which are then examined in the context of therapeutic communities that treat "substance abusers." Although female drug abusers form a significant proportion of the drug abusing and treatment population, very little research has focused on them. Two studies by Levy and Doyle (1974 and 1975) exploring the attitudes toward women in a therapeutic community and in a methadone maintenance program are discussed. The data on the therapeutic communities indicate that most staff members treat men and women differently and feel justified in doing so. Women are viewed as more dependent more emotional and "sicker" than men. Job training and assignments reflect this sex-role stereotyping, which is shared by male and female staff. Pointing out that both sexes suffer from discriminatory practices directed at women, the authors go on to describe the problems facing female staff and residents in residential therapeutic community programs. Most women entering a therapeutic community program have a history of negative experiences related to their femininity and concept of womanhood. Their entrance into the therapeutic community brings them face to face with both bodily and psychic symptoms. A sensitively conducted gynecological examination at the beginning of treatment is suggested as a way of helping women understand the connections between their bodies and minds. Although most female clients try to emulate a traditional super-feminine ideal in the beginning of treatment, only tough and aggressive behavior is valued in the therapeutic community. Women are often confused by the fact that character traits defined as feminine are held in complete disdain. On the basis of their own observations, the authors report that very few clients have leanings toward feminism. The attitudes of staff members toward women are very traditional, and work that has been done on the value of feminist therapy for women has no place in the vast majority of therapeutic communities. The authors list the many biases practiced against women in therapeutic communities, giving special attention to double standards concerning sexual behavior and sexual voyeurism. The same kind of discrimination affecting female patients is faced by female staff members. The authors suggest that if attitudinal training and consciousness-raising are used, members of both sexes should be included. The study by Maccoby et al. (1974) on the lack of evidence of differences between the sexes is cited to back the authors' plea for an examination of androgyny. Rigid definitions of masculinity and femininity are identified as a disservice to both sexes. The authors maintain that the concept of androgyny offers a personal psychology in which both men and women are free to experience their full human capacities and would be very valuable if used in therapeutic communities.

69.

Peak, Jeanie L., and Glankoff, Peter. "The female patient as booty." In: Senay, Edward; Shorty, Vernon; and Alksne, Harold, eds. *Developments in the Field of Drug Abuse: Proceedings 1974 of the National Association for the Prevention of Addiction to Narcotics.* Cambridge, Mass.: Schenkman Publishing Company, Inc., 1975. pp. 509-512.

This article focuses on the sexual exploitation of female drug abusers in treatment programs. The authors describe the culturally supported view of woman as a wife/mother who may take drugs to help her through her emotional and physical trials. When women defy society's role expectations and openly use drugs for pleasure, they are considered far more deviant than their male counterparts. The authors suggest that in the eyes of much of society, drug abuse turns a woman into a selfish pleasure seeker who is no longer able to fulfill her role as servant. They report that women who seek treatment for drug problems are often made to feel guilty more because of their failure to conform to role expectations than because they have been self-destructive. In rejecting the acceptable feminine role, the drug abuser made herself a "bad" woman who is fair game for men's sexual needs. The authors believe that it is this form of thinking that allows male counselors to sexually exploit their female clients. From the society's perspective, these women cannot be exploited, because they have rejected the roles that offered them protection within the social code. Examples of sexual exploitation and the administrative reaction to it are cited. The authors assert that most programs have consistently refused to make and enforce policies governing this issue. Sexual exploitation, when it occurs, is usually carried out by counselors who come from the patient population. These counselors have the lowliest jobs in drug treatment programs and have no access to the rewards and better jobs higher-ups receive. In conclusion, the authors suggest that sexual exploitation can be combated by guaranteeing ongoing staff advancement and ensuring that staff training on all levels encourages the elimination of sexist attitudes in treatment.

70.

Peterson, Gail Beaton, and Peterson, Larry R. Sexism in the treatment of sexual dysfunction. ***The Family Coordinator,*** **22(4): 397-404, 1973.**

This study examines how the most frequent sexual problems of men (premature ejaculation and impotence) and women (orgasmic dysfunction) are dealt with in popular sex and marriage manuals. The purpose is to determine whether sex bias is present in the information and instructions provided. Special attention is given to the suggested causes and cures for these problems. The authors confined their research to paperback manuals, considering these to have wider availability and to be referred to more frequently. They developed a list of 24 books representing 19 authors; each manual was read separately by each of the two researchers. Causes and remedies proposed for each of the sexual problems were tabulated. A test of nonindependent proportions was run comparing the causes and cures for each male problem and the causes and cures for the female problem. Of 40 possible causes and 22 possible aids, a total of 40 items differed at statistically significant levels. These statistically significant differences form the basis for a discussion on the different treatment the manuals suggest for men and women. The authors note that in the world of sex manuals, when things are going well for a couple, there may be heavy demands placed on the male. When problems arise, however, the reasons and aids for each sexual difficulty involve the female. Perhaps because of cultural expectations, women become both the cause and the cure. Women's problems are related to their cultural conditioning, whereas men's problems have their cause in the present situation. Women are given an active responsibility and role in helping to cure masculine dysfunction but are expected to work out their own problems by themselves. According to the manuals, premature ejaculation and impotence most often originate in the female partner's behavior, so it is only "just" that she take an active role in the cure. A woman's problems are caused by her own past, and she alone can change its impact on her. Several specific contradictions found in the manuals are described. Women are generally expected to fulfill the traditional feminine role and, according to the authors, are too readily asked to accept resonsibility for the causes and corrections of both male and female problems. The authors present the implications of this research for sex education and counseling. Sex education based on an egalitarian orientation would encourage women to explore their own and men's bodies. Men must come to realize that sex is not their responsibility alone, and they must get over their feelings of anxiety based on myths about being a "real man." Men and women must learn to communicate to each other about sex without embarrassment. By the same token, counselors must be aware of possible sexism in their work and keep their minds as free from sexist bias as possible.

71.

Roth, Robert T., and Lerner, Judith. Sex-based discrimination in the mental institutionalization of women. *California Law Review*, 62(3):789-815, 1974.

This article deals with sex-based discrimination in the mental institutionalization of women. It is specifically directed to attorneys to help them guard against abuses of their female clients at commitment and release proceedings. Evidence presented suggests that what appears to be a strictly medical diagnosis may actually have its basis in norm and prejudice. In a section that discusses sex-based discrimination in psychiatric theory, the authors point out that the criteria used to diagnose women as either mentally ill or healthy are different and more restrictive than those applied to men. They suggest that this practice may stem from the psychiatric belief that a woman's anatomy determines her destiny and from psychology's tradition of viewing the individual in isolation without regard to social and historical context. They discuss and document indications of discrimination in all three phases of incarceration for mental illness—admission, treatment, and release. Although women, because of their inferior economic position, are more vulnerable to institutionalization than their male counterparts, the following groups of women are especially so: dependent, runaway, or sexually active adolescent females; sexually active adult women; sexually active single mothers who receive State financial assistance; and women involved in custody suits. In that there is no clear statutory framework for commitment and release, psychiatric judgment is relied on and psychiatric stereotypes about women dominate the process. Conditioning in and enforcing of sex stereotypes are often a part of institutional treatment. Examples are given of how rewards and punishments are meted out on the basis of conformance to these sexual stereotypes, such as performing domestic chores, dressing up, and acting submissive. Role conditioning often takes coercive forms, with women being severely punished for mildly aggressive behavior or sexual acting out that would be tolerated in men. Shock treatment is a frequent punishment and women receive psychosurgery three times as often as men in the effort to domesticate them. A study is cited showing that women have a better chance for release if they have limited education and possess only domestic skills. Women schizophrenics are more likely to be released if they appear weak willed and anxious, fulfilling the clinician's view of correct female behavior. A protective feeling toward women on the part of many clinicians may also prevent women from being quickly released. In that the standards used to incarcerate people in mental institutions are supposedly "medical," the modus operandi is personal rather than legal—only qualified experts can determine how the system is working. Objective outside supervision cannot penetrate, since decisions are ultimately based on faith in the professional expertise of physicians rather than on community judgment. The authors suggest that the myth of mental illness is being challenged, because there is no evidence that bizarre or dysfunctional behavior is directly caused by "mental disease" in the manner of physiological disorders. The vagueness of many of psychiatry's diagnostic terms makes it easy to conceal clinicians' political and cultural preferences under the guise of neutral judgments about an objectively verifiable disease. The authors conclude by suggesting how attorneys can combat sex-based discrimination at commitment and release hearings.

72.

Schlossberg, Nancy K., and Pietrofesa, John J. Perspectives on counseling bias: Implications for counselor education. *The Counseling Psychologist*, 4(1):44-54, 1973.

Relevant research surrounding the problem of counselor bias is discussed, and a training model to help counselors reduce sex bias is proposed. Counselors, like all people, tend to make pre-judgments about the behavior appropriate for specific groups of people, and these assumptions are reflected in counseling interviews. The authors believe that this bias must be acknowledged and acted upon. As traditional ideas about sex roles are increasingly being challenged, counselors must become aware of the degree to which their own sex biases affect their advice to clients. Several studies on sex bias are cited extensively to establish that counselors do ascribe specific roles to men and women based on societal sex-role stereotypes and that their interview behavior reflects this sex bias. Practitioners are often unaware not only of their own sex biases, but of biases in the descriptive materials, tests, and measurements they use. The Strong Vocational Interest Blank exemplifies such bias, with its exclusion of many occupations for women that are available to men and vice versa. This particular instrument is being revised to eliminate bias, and similar revision is recommended for all guidance tests, materials, and occupational information used by counselors. Counselor education programs must accept counselor bias as fact, according to the authors, so that counselors can become sufficiently aware of biases to control or eliminate them completely from their counseling. As an example of the kind of antibias materials that must be developed for training, the authors present a four-pronged training model designed to enable counselors and teachers to work with their clients in an unbiased fashion. This model is based on a 56-hour course conducted by the authors, which is described as most effective as 1 intensive week of training with 16 hours of followup during the year. The four aspects of the training program are (1) expanding the trainees' cognitive understanding about women's roles through lectures and readings; (2) raising the participants' consciousness regarding their sex bias, using various group techniques; (3) facilitating the development of nonbiased helping skills through audiovisual taping and role playing of counseling and supervised practice; and (4) working on program development skills so that the trainees can create new and innovative programs designed to result in better situations for women. Each of these is described in some detail.

73.

Schwartz, Mary C. Importance of the sex of worker and client. *Social Work*, 19(2):177-185, 1974.

In a survey of social work literature over the last 8 years, Schwartz attempts to determine how sexual identity has been integrated into professional thinking. Although the influence of therapist's sex on the therapeutic process has been prolifically reported in the psychotherapy literature, little attention to this issue is evident in the social work literature. Schwartz indicates that sex is ignored by writers on social work even though class and race are dealt with as significant factors. She further suggests that the findings of several studies on interracial casework might have been different if sex of worker had been considered. Only one of the two studies of male-female co-therapists that were reviewed took therapist's sex into consideration. The issue of client sex, even when mentioned in the literature, was inadequately analyzed. Schwartz points out that studies dealing with parent-child relationships failed to discuss the differences in men's and women's relationships to their children as determined by their sex-role socialization. Similarly, studies focusing on mourning for children and the relations between parents and their adult children overlooked the role sex plays. Studies of special client groups, such as delinquents, patients in mental hospitals, and people on welfare, also failed to discuss the significance of sex. The obvious importance of sex in the interpretation of studies on these client groups is identified. According to the author, studies dealing with sex role differences have offered no meaningful analysis of how expectations for men and women differ in this culture and the effects of this difference. Schwartz concludes the role of sex has not been integrated into professional thinking. She asserts that social workers' understanding of themselves and their clients will not reflect a more complete reality until they integrate their understanding of the importance of race, class, and ethnicity with that of sex.

74.

***Women Against Electric Shock Treatment.* Women's Press Collective, 5251 Broadway, Oakland, Calif. 8 pp.**

Two women who received electric shock treatment (EST) and two women who worked in hospitals where EST is a daily procedure voice their opposition to this form of treatment. They believe EST is a method of controlling women and of silencing their rebellion.

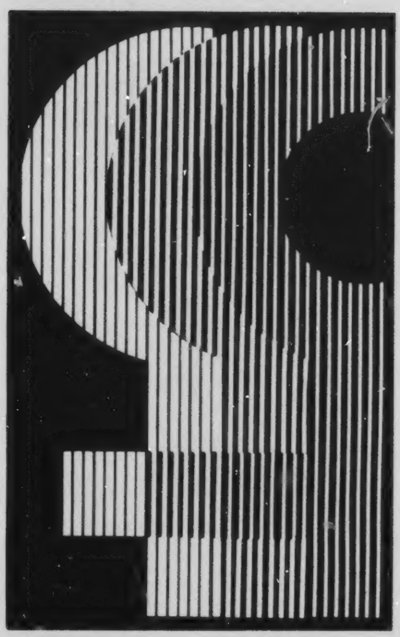
They identify women's depression in this society as valid and caused by external political conditions. The different standards for men and women in the society are responsible for women becoming the main victims of EST. Included in this pamphlet is a transcript of a television program in which the authors articulated their opposition to EST, revealing that it destroys memory and creates confusion. Because EST temporarily alleviates depression and its use is accompanied by considerable positive reinforcement from psychiatrists, people often become dependent upon both the treatment and their therapists. The authors encourage active opposition to a treatment that promotes dependence and destroys the sense of power and control over one's own life.

75.

Wynn, Karen, and Clement, Patrick. The junkie treatment. ***Human Behavior*****, 6(7):17-21, 1977.**

This article is an angry indictment of the treatment of women in federally funded drug abuse programs. It is based on a study conducted by the Women's Health Advocates in 1974 and 1975 (edited version published by the Drug Abuse Council, Washington, D.C.). Seventy of the women who had been through treatment were interviewed; 30 had been in methadone maintenance, and 40 had been involved in residential therapeutic communities (TC's). The authors criticize treatment programs, such as Synanon and Daytop, that use a therapy method invented in the 1960's by ex-addicts to treat other addicts. They indicate that these programs, which are based on confrontational and stressful peer counseling, are totalitarian in nature, demanding that residents totally realign their personalities to meet the communities' goals and values. Of the 40 women interviewed who spent time in TC's, 75 percent were there because of legal pressure. If given the choice of doing it all over again, 40 percent indicated they would spend the time in jail rather than in a TC. The women on methadone maintenance were generally older, in the program by choice, and seemed to fare better. However, 58 of the 70 women interviewed reported they had been abused or exploited in their treatment programs. According to the authors, these treatment programs are closed systems with their own values and assumptions about women addicts, who are categorized into four types: the whore, the hypochondriac, the bad mother, and the intellectual junkie. The goal of treatment is to reverse these labels. Testimony from the interviews is used to illustrate the treatment the women receive. In some programs women were able to control their treatment by forming sexual liaisons with male staff, since women addicts are assumed to have sexual problems anyway. Emotionality is emphasized in these settings, and there is a contempt for intellect and rationality. Medical attention is often denied because addicts are labeled hypochondriacs, and women are badgered about being bad mothers. The authors discuss the abuse women encounter in the male-female group therapy sessions run by the treatment centers, noting that justified anger is channeled into hostility groups and diffused. The various forms of punishment used by TC's are described. Any self-assertive behavior is identified as evidence of a "sick junkie mentality," and any hostility is perceived as a reflection of the individual's emotional problems. The authors report on the lack of review boards and ignorance on the part of administrators about the abuse of women that occurs. Noting that only a few uncontrolled followup studies on treatment effectiveness have been done, Wynn and Clement recommend a systematic examination of what goes on in drug treatment programs.

III.
RESEARCH RESPONSE TO CRITICISM



Influence of Patient's/Therapist's Sex on Clinical Judgment

Effect of Sex of Client/Therapist on Process and Outcome of Therapy

Effect of Sex of Client on Process and Outcome of Various Treatment Approaches

Overviews of Research

Influence of Patient's/Therapist's Sex on Clinical Judgment

76.

Abramowitz, Stephen I., and Abramowitz, Christine V. Should prospective women clients seek out women practitioners? Intimations of a "ding-bat" effect in clinical evaluation. *Proceedings, 81st Annual Convention, American Psychological Association,* 8(1): 503-504, 1973.

Noting that studies have shown women tend to internalize a cultural stereotype of themselves as emotionally unstable, the authors report on their investigation of whether this finding could affect the therapeutic relationship for women patients who have female therapists. Personality and intelligence tests, including the Rotter Incomplete Sentences Blank (ISB), were given to 81 female and 71 male nonrandomly selected university students. Males and females gave significantly different responses to the ISB, with females expressing a more misogynous viewpoint that revealed a perception of less psychiatric soundness in women. In a second experiment, 23 female and 48 male mental health or education professionals were given a bogus case history and asked to rate the "client" on a 4-point scale from "very poorly adjusted" to "not poorly adjusted at all." Two versions of the same history, one using the name Jane and one John, were distributed randomly. Females gave significantly lower ratings to the female case history than males did. Other trends indicate that female patients will be judged more harshly than males by therapists of both sexes. The authors note that although the sample's regional and professional homogeneity limits generalizability, results indicate the need for more efforts toward the development of a social psychology of professional mental health services.

77.

Abramowitz, Stephen I.; Abramowitz, Christine V.; Jackson, Carolyn; and Gomes, Beverly. The politics of clinical judgment: What nonliberal examiners infer about women who do not stifle

themselves. *Journal of Consulting and Clinical Psychology*, **4(3): 385-391, 1973.**

This study investigated the hypotheses that the political beliefs of professional counselors, the similarity of these beliefs to a student's beliefs, and the sex of the student will influence the professional's assessment of the psychological status of the student. A sample of professionals was drawn from participants in a 1972 Southeastern Conference of Counseling Center Personnel. Seventy-one individuals, 70 percent of the sample, completed the 10-minute questionnaire. Answers revealed that 70 percent of the respondents used clinical tests on a daily basis. Although few demographic data were collected, it was estimated that 30 percent of the participants were female and 15 percent were black. Embedded in the first part of the questionnaire were five Likert-type scales used to classify 40 respondents as "more liberal" and 31 as "less liberal." Of the female respondents, 11 were classified as more liberal and 12 as less liberal. In the second set of questions, subjects were randomly assigned one of four histories that reported identical scores on three "psychological adjustment tests." Depending on the version of the history, the student was described as either a left-oriented male, a right-oriented male, a left-oriented female or a right-oriented female. The professionals were compared in their responses to a rating of the student's psychological comfort on a Likert-type scale that ranged from very poorly adjusted to not poorly adjusted at all. A three-way analysis of variance revealed that of the three main effects (i.e., politics of the examiner, sex of the testee, and politics of the testee) only the politics of the testee was significant ($p < .10$). Students of a leftist political persuation were evaluated less favorably than their rightist counterparts. A significant interaction was reported for the variables, politics of the examiner and sex of the student ($p < .05$). The clinical inferences are less strongly related to the evaluator's political persuasion for men than they are for women. Less liberal professionals judged the psychological status of women most severely. The remaining significant interaction was the three-way interaction ($p < .025$). For students described as having a leftist political orientation, the less liberal examiners gave males a better mean adjustment rating and females a lower mean adjustment rating than did the more liberal examiners. For students described as having a rightist political orientation, both more and less liberal examiners described the females as having a higher mean adjustment rating than males. The less liberal examiners provided lower ratings than the more liberal examiners for both males and females. The authors conclude that there is support for their original hypothesis that political opinions shape clinical judgments, and that there is a bias against left-oriented women who are politically active. The finding that nonliberal counselors rated a liberal oriented female as less adjusted when compared to a liberal oriented male is considered particularly provocative, since clinical judgments are increasingly being used by employers, community leaders, and the general public.

78.

Abramowitz, Stephen I.; Roback, Howard B.; Schwartz, Joseph M.; Yasuna, Amy; Abramowitz, Christine V.; and Gomes, Beverly. Sex bias in psychotherapy: A failure to confirm. ***American Journal of Psychiatry*****, 133(6):706-709, 1976.**

This study attempted to determine whether conventionally trained, experienced group therapists had a sociopolitical bias reflected in their reactions to persons of different sexes. A random sample stratified on the basis of sex was drawn from a listing of the members of the American Group Psychotherapy Association. Of the sample of 600, 65 males and 57 females responded to questions about their clinical impressions, attraction to, and recommended treatment for a client. The client was described as a group therapy outpatient whose prominent problems were sexual performance conflicts and hostile-dependent dynamics. The case description concluded with information about a group meeting in which the patient was first unusually quiet and then began to cry. The patient's sex was randomly designated as male or female in the case descriptions, which were mailed to the therapists. A letter to each therapist stated that the purpose of the study was to compile normative data on therapists' clinical impressions. A traditional moralism scale, which was also included in the material mailed to each therapist, was used to measure the traditionalism of the therapist's values. Analyses of variance were carried out to examine the relationships between the therapist's responses and the factors of therapist's sex, therapist's values, and patient's sex. There was little effect of varying the patient's gender in the case study, except that the female patient tended to receive a better prognosis, to be viewed with more empathy, and to be recommended for individual rather than group therapy. Statistically significant differences related to the therapist's sex were the following: female therapists had higher levels of expressed empathy for the patient, more often provided a psychodynamic interpretation of the client's problem, more often chose behavior change and subtle guidance as strategies, and less often chose clarification-confrontation as a strategy. Statistically significant findings from the analyses of effects of traditional values were that less traditional respondents tended to be more lenient judges of emotional maturity and to recommend the use of clarification-confrontation, while more traditional respondents recommended behavior change and subtle guidance. A number of interactional effects significant at the .10 level are also reported. The authors conclude that there is little evidence of sociopolitical bias among group therapists. They review alternative explanations of their finding that the patient's sex is not significantly related to many of the therapist's responses, such as the possibility that the therapists were aware of the true purpose of the study.

79.

American Psychological Association. Report of the Task Force on Sex Bias and Sex-Role Stereotyping in Psychotherapeutic Practice. *American Psychologist.* 30(12):1160-1175, 1975.

This Task Force report identifies and discusses the lack of research on the issues of sex bias and sex-role stereotyping along with some of the problems that can arise when women seek therapy. An open-ended questionnaire was mailed to 2,000 women members of the American Psychological Association who were assumed to have experience as both consumers and practitioners of psychotherapy and a vested interest in responding. The questionnaire was designed to elicit descriptions of incidents or circumstances the respondents perceived as indicative of sex bias or sex-role stereotyping in psychotherapy with women. Four major areas of bias and stereotyping in therapy emerged in the 320 responses received—fostering traditional sex roles, bias in expectations and devaluations of women, sexist use of psychoanalytic concepts, and responding to women as sex objects. In an examination of each of these areas, verbatim responses that illuminate the issues involved are provided. Some of the themes that emerged in relation to fostering traditional sex roles included therapists assuming that perfecting the marriage or wife role will solve a woman's problems, family and child therapists supporting the idea that child-rearing and the child's problems are strictly the mother's responsibility, and therapists lacking awareness and sensitivity to women's career, work, and role diversity. Regarding bias in expectations and devaluation of women, the following themes were revealed: therapists denying adaptive and self-actualizing potential or assertiveness for women, ignoring or condoning victimization of women on the basis of psychological theory, and demeaning women by telling sexist jokes or using demeaning labels to describe them. The themes presented in the area of the sexist use of psychoanalytic concepts included therapists maintaining that the vaginal orgasm is a prerequisite for emotional maturity and labeling assertiveness and ambition as manifestations of penis-envy. Seduction of a female client by her therapist and therapists using double standards to judge male and female sexual behavior are among the themes that emerged in the area of responding to women as sex objects. Additionally, respondents provided information on treatment they considered valuable for women, told of how sex bias and stereotyping influenced their careers, and gave suggestions for eliminating sexism in therapy. Based on the survey results and the overall work of the Task Force, several recommendations were made. The Report's authors identify the need for consciousness-raising and increased sensitivity to the problems of sex bias and sex-role stereotyping in psychotherapy, and they suggest specific activities for accomplishing this. Additionally, the authors cite a need for developing guidelines for nonsexist psychotherapy and for informal criteria and procedures to evaluate the education and training of psychotherapists in the psychology of women, sexism in therapy, and other related issues. They further suggest that the Ethical Standards of Psychologists should include statements regarding sexism and that the Task Force on Sex Bias be continued in order to create guidelines for nonsexist therapy, to establish criteria for education and training, to develop procedures for obtaining information from consumers about sexism in their therapy, and to investigate the issues surrounding sexual intimacy in psychotherapy.

80.

Berland, Nancy Susan Winnik. The effect of sex and sex-role on psychodiagnosis. (Abstract source, *Dissertation Abstracts International*, 36(B):4678, 1976.) *Dissertation Abstracts International.* Ann Arbor, Mich.: University Microfilms, No. 76-4742. 166 pp.

Berland investigated how the sex of the patient can influence clinicians' diagnostic assessment and examined the effect of differing levels of pathology and congruent or incongruent sex-roles on clinical assessment. She hypothesized that males would be judged more severely than females in cases of intermediate pathology (neurotic) and that individuals who displayed inappropriate sex-role behavior (masculine females and feminine males) would be rated as more disturbed. Forty psychiatrists rated each of 12 cases which varied along levels of pathology (psychotic, neurotic, normal), sex (male, female), and sex role (masculine, feminine). Ratings were made on four 9-point scales—health, need for treatment, likelihood of following recommendations, and likability—as well as on a modified Q sort that measured degree of psychopathology. An *a priori* 3 × 2 × 2 analysis of variance with repeated measures on all factors was done for each variable. Because a three-way interaction between pathology, sex, and sex role did not occur, the major hypothesis was rejected. Berland notes, however, that both pathology and sex did occur as main effects. On every dependent variable, psychotics were rated as more disturbed than neurotics, who were rated as more disturbed than normals. Males were rated as more disturbed than females across all levels of pathology on three of the five variables. Berland indicates that a number of post-hoc analyses were performed in which the subject population was divided into liberal and conservative, according to their attitudes toward the changing roles of men and women in the society. The results reflect complex interactions between the subjects' attitudes and the three independent variables. The author suggests that this area of personal bias in clinicians might be the most useful and productive area for further research.

81.

Billingsley, Donna. Sex bias in psychotherapy: An examination of the effects of client sex, client pathology, and therapist sex on treatment planning. *Journal of Consulting and Clinical Psychology,* **45(2):250-256, 1977.**

Billingsley investigates whether the therapist is influenced by client sex and presenting pathology when formulating treatment goals for a client. She writes that treatment plans for male and female clients might be expected to emphasize increases, respectively, in stereotypically "male" and "feminine" behaviors. Factors in a 2 × 2 × 2 factorial design were therapist sex, pseudoclient sex, and pseudoclient pathology. Sixty-four therapists received a case history of a client who had serious difficulties in all areas of living and of one who had recently experienced problems in going to work as a result of an automobile accident. The first client was considered explosive, and the second was considered restricted. Each therapist received descriptions of clients of the same sex in order to disguise the purpose of the study. The practicing male and female therapists who had volunteered to participate in the study had been trained in several disciplines. They were asked to choose six initial therapy goals from an 18-item checklist. The items were nine male- and nine female-valued behaviors from the Stereotype Questionnaire. A ratio of male to female items was formed for responses pertaining to each case history. The analysis of variance revealed a significant effect for client pathology ($p < .001$). Therapists chose significantly more feminine treatment goals for the explosive client than the restricted client ($p < .001$). Female therapists chose a greater number of masculine treatment goals, whereas male therapists chose a greater number of feminine treatment goals ($p < .025$). Client sex was not shown to be related to psychotherapists' treatment goal choices. The author interprets her findings in light of contradictory findings of other researchers. On the basis of the data available from this study, Billingsley concludes that client sex does not influence treatment goals when client pathology is well defined, adding that whether client sex influences treatment goals when vague or mild pathologies are described remains to be demonstrated.

82.

Broverman, Inge K.; Broverman, Donald M.; Clarkson, Frank E.; Rosenkrantz, Paul S.; and Vogel, Susan R. Sex-role stereotypes and clinical judgments of mental health. ***Journal of Consulting and Clinical Psychology*****, 34(1):1-7, 1970.**

The authors made the following hypotheses: (1) Clinical judgments regarding the characteristics of healthy adults would differ as a function of the sex of the person judged and would parallel stereotypic sex-role differences; (2) Behavioral attitudes which are considered to reflect an ideal standard of health for an adult, sex unspecified, will more often be regarded by clinicians as appropriate for men than for women. A sex-role stereotype questionnaire (Rosenkrantz et al., 1968) consisting of 122 bipolar items was administered to 79 (46 male and 33 female) psychiatrists, psychologists, and social workers aged 23-55 who were actively working as clinicians. Separate groups of therapists were instructed to describe a healthy, mature, socially competent (1) adult, sex unspecified ($N = 15$ men, 11 women), (2) a man ($N = 17$ men, 10 women), or (3) a woman ($N = 14$ men, 12 women). Analysis was done only on the stereotypic questionnaire items that reflect highly consensual, clear distinctions between men and women, as perceived by lay people. The questionnaires were scored by counting the number of subjects that marked each pole of each stereotypic item within each set of instructions. "Agreement" and "health" scores were developed. None of the *t* tests used to compare the masculinity, femininity, and adult agreement and health scores of the male clinicians to those of the female clinicians were statistically significant, and all further analyses were performed with the samples of men and women combined. For the adult, the masculinity, and the femininity agreement scores, the average proportion of subjects agreeing to which pole reflects the more healthy behavior or trait was significantly greater than the .50 agreement expected by chance, indicating that the clinicians strongly agree on the behaviors and attitudes which characterize a healthy man, a healthy woman, and a healthy adult independent of sex. On 27 of the 38 stereotypic items the male pole is perceived as more socially desirable by a sample of college students (male-valued items); the feminine pole is seen as more socially desirable on 11 items (female-valued items). On 25 of the 27 male-valued items, the masculinity health score exceeded the femininity health score; 7 of the 11 female-valued items have higher femininity than masculinity health scores. On four of the female-valued items, the masculinity health score exceeded the femininity health score. A significant chi-square is produced, indicating that clinicians tended to consider socially desirable masculine characteristics more often as healthy for men than for women, but only about half of the socially desirable feminine characteristics were considered more often as healthy for women rather than for men. The authors note that among these items, clinicians were more likely to suggest that healthy women differ from healthy men by being more submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, more subject to having their feelings hurt, more emotional, more conceited about their appearance, less objective, and disliking math and science. The results of *t* tests performed between the adult agreement scores versus the masculinity and femininity health scores indicate that the adult and masculine concepts of health do not differ significantly whereas a significant difference does exist between the concepts of health for adults versus females. The authors conclude that (1) the results of this study indicate a high agreement among clinicians as to the attributes characterizing healthy adult men, healthy adult women, and healthy adults; (2) this agreement holds true for both men and women clinicians; and

(3) their hypotheses were confirmed. They suggest that this double standard of health for men and women is related to an "adjustment" concept of health on the part of clinicians. The authors discuss this concept and recommend that clinicians critically examine their attitudes regarding sex-role stereotypes and their position in relation to an adjustment notion of health, and that they encourage both men and women to fully realize their individual potential rather than continuing to help people adjust to existing and restrictive sex roles.

83.

Brown, Caree Rozen, and Hellinger, Marilyn Levitt. Therapists' attitudes toward women. *Social Work*, 20(4):266-270, 1975.

Brown and Hellinger, two social workers, report their observations that many mental health professionals maintain a double standard of mental health that is based on sex-role stereotypes. They cite the Broverman et al. (1970) study which corroborates their observations, and Brogan's 1971 study, which presents opposite findings. They examine this inconsistency, pointing out that a review of the behavioral science literature from the early 1900's to 1975 reveals a "monolithic point of view" toward woman—she was defined by her anatomy, perceived as passive and submissive, and her primary tasks were identified as homemaking and child rearing. Before the 1960's no important argument appeared to challenge this viewpoint, and the current positive contemporary attitude toward women is considered too new to have had much impact on the training of therapists. Brown and Hellinger developed a questionnaire to test their three hypotheses concerning therapists' views of women: (1) therapists' attitudes toward women are more traditional than contemporary; (2) female therapists have a more contemporary attitude than male therapists; and (3) social workers have a more contemporary attitude than other therapists. The sample group was a total of 274 psychiatrists, psychiatric residents, psychologists, social workers, and psychiatric nurses from three mental health facilities in Montreal. The questionnaire was divided into a section on demographic data, a section to determine attitudes toward women with use of a Likert scale, and a final section for the therapists to self-rate their attitudes toward women. The means for determinining a traditional or contemporary attitude are presented along with a list of statements used in the second section of the questionnaire to assess attitudes toward women.

The authors acknowledge possible limitations to the study's validity, such as the self-selection of the sample, the limited scope of the attitudinal items in the questionnaire, and the selection of the sample from a limited population. They report that their hypothesis that therapists' attitudes toward women are more traditional than contemporary was not supported, although 50 percent of the respondents did hold traditional attitudes toward women. The hypothesis that female therapists have a more contemporary attitude than male therapists was statistically supported ($p < .05$), but the third hypothesis—that social workers have a more contemporary attitude than other therapists—was not. Psychiatric nurses were found to have the highest ratings of contemporary attitudes. Therapists are advised to examine their own biases and accept alternative modes of living so that deviance will not be identified as neurosis. The authors suggest that their questionnaire could be used on an individual basis to evaluate therapists' attitudes toward women and to increase self-awareness. The next logical step in this research area is identified as an assessment of how therapist attitude, practice, and effectiveness are related.

84.

Collins, Anne M., and Sedlacek, William E. Counselor ratings of male and female clients. *Journal of the National Association of Women Deans and Counselors,* 37(2):128-132, 1974.

The authors cite their belief that women need psychotherapeutic assistance to overcome internalized barriers to acquiring more autonomy. They also refer to the findings of Broverman et al. (1970), which suggest that a double standard of mental health for men and women may make therapists unprepared to help women in this process. To test this assumption, the authors devised a study to determine areas in which male and female clients in a university setting were perceived and treated differently by counselors. Study data consist of ratings made by nine male and four female Ph.D. counselors of all clients seen at the University of Maryland Counseling Center from June 1970 to June 1971. The Codebook of Counseling Categories was used to rate 565 women and 645 men on 16 items, including demographic variables, intake assessments, process judgments, and termination ratings. Frequency and percentage distributions were examined for the total sample of clients and for eight subgroups based on sex and marital status of clients and sex of counselor. Due to the small number of persons in many of the subgroup cells, chi-square tests were not possible for these groupings. Although space limitations precluded the publication of tables, they are available from the authors on request. The authors report that 5 of the 16 items showed a statistically significant difference ($p < .05$) between ratings of male and female clients. The major difference was that males were more likely to be rated as having vocational-educational problems, in contrast to women, who were more often rated as having emotional-social problems. Additionally, individuals who were married were rated as having more emotional-social problems than single people. No statistically significant difference was noted in how male and female counselors rated clients, although clients of both sexes were less likely to keep a first interview appointment with a woman counselor. This situation was reversed in subsequent appointments, indicating that initial reluctance to see a woman counselor may have been dispelled by an actual meeting. The authors suggest that the differences in ratings can be explained in several ways: as a reflection of "real" differences between men and women, as a reflection of the counselors' sex stereotyping, or as an interaction of both. They claim that the data offer no sound rationale for explaining the differences but do provide evidence that systematic differences exist. Directions for further and more specific studies are suggested.

85.

Cowan, Gloria. Therapist judgments of clients' sex-role problems. *Psychology of Women Quarterly*, 1(2):115-124, 1976.

The author reports on her study of sex-role stereotyping and judgments about the mental health of clients by clinicians. One specific hypothesis of the study was that therapists perceive women in therapy as failing to meet feminine norms. The competing hypothesis was that therapists view women in therapy as failing to have culturally valued male characteristics. Another issue addressed was whether men or women were judged to have more sex-role-associated problems. The Sex-Role Stereotype Questionnaire developed by Rosenkrantz et al. (1968) and modified by Broverman et al. (1970) was mailed to 115 members of the Michigan Society of Consulting Psychologists; 30 usable forms were returned. Answers to questions designed to measure sex-role stereotypes were scored in such a way that measures were obtained of the therapists' views of (1) whether patients usually had problems that could be classified as reflecting feminine or masculine stereotypes and (2) whether female or male patients had these problems more often. A high score on the female stereotypic items and a low score on the male stereotypic items indicated that the patient was viewed as "too" feminine. The subjects were also directly asked about the relationship of their sex-role expectations to clients' problems. A repeated-measures analysis of variance showed an overall significant effect of male- and female-valued items and sex of clients on therapist judgment. The Newman-Keuls test showed that all pairs of means, except for the female-valued items for male clients, were significantly different from each other at an .01 level. Female clients were viewed as "too" feminine on both socially desirable and undesirable traits. Males were not similarly viewed as "too" masculine. Finally, therapists did not feel that men had fewer problems resulting from sex-role expectations than did women. Prior studies have suggested that a double standard is used to judge the mental health of men and women. The findings of this study, however, indicate that a male standard rather than a double standard was used to judge women. Therapists consider both positively valued and negatively valued stereotypically feminine characteristics as unhealthy for women in therapy.

86.

Cowan, Margie L.; Weiner, Elliot A.; and Weiner, Barbara J. Therapist perceptions of clients and client self-report. ***Journal of Clinical Psychology*****, 30(2):227-230, 1974.**

Agreement between therapists' perceptions of typical clients and clients' views of themselves, as well as the influence of therapist and client sex on this agreement, was studied. Subjects were clinicians (35 males, 17 females) and new clients (39 males, 13 females aged 14-72) from four agencies in a midwestern university city—the university counseling center, a mental health center, an independent psychological guidance center, and a county mental health guidance center. Scores for anxiety, depression, and hostility were obtained from the Multiple Affect Adjective Checklist (MAACL). Both the therapists and the clients filled the form out to describe the feelings of the clients. The therapist knew only the sex of the client and that the client was an adult. Univariate analyses of variances were carried out to compare the mean scores for anxiety, depression, and hostility and to examine the effect of the type of agency, sex of the therapist, and sex of the client on MAACL scores. All therapists rated the typical clients as more anxious, depressed, and hostile than the clients rated themselves ($p < .01$). Some significant differences according to sex were also found: (1) therapists perceived males as more hostile than females ($p < .10$); (2) male therapists viewed clients as more anxious ($p < .10$) and more depressed ($p < .25$) than did the female therapists; (3) male therapists rated female clients more anxious than female therapists rated them ($p < .02$). There were no significant differences between male and female clients in self-ratings, or between male and female therapists' ratings of clients. In addition to sex-related differences, the effects of the type of agency are also reported.

87.

Delk, John L., and Ryan, Timothy T. Sex role stereotyping and A-B therapist status: Who is more chauvinistic? *Journal of Consulting and Clinical Psychology*, 43(4):589, 1975.

The authors report on their investigation of the relationship between A-B therapist status and attitudes regarding sex roles for the mentally healthy adult male and female. Seventy-six male and female psychotherapists and medical and nursing students completed the University of Kentucky version of the A-B Psychotherapist Scale. Seventeen A and 20 B therapists, representing, respectively, the lowest and highest quartiles of scores, were selected from this group. Sex-role stereotyping scores for all subjects were obtained through the use of a 38-item bipolar scale, adapted from Broverman et al. (1970). Noting that previous researchers have used "separate forms" of male and female ratings administered sequentially, the authors relate that each subject was asked to indicate on a "single form" where, on each item, they thought a "mentally healthy adult male" and a "mentally healthy adult female" should rate. The mean difference score, representing a subject's average rating of the mentally healthy adult male in the more socially desirable direction, constituted the sex-role stereotype index. The authors report that analysis of variance showed that A therapists stereotyped to a greater degree than B therapists ($p < .01$). There was no statistically significant difference in sex-role stereotyping between the four groups of subjects—male and female professional therapists and male and female students. However, female professional therapists tended to stereotype least, a finding approaching statistical significance. Additionally, *t* tests revealed no statistically significant difference between groups on the A-B therapist scale. Pointing out that their results indicate that A therapists were significantly more prone to sex-role stereotyping than B therapists, the authors discuss the question of who is more likely to help female patients become self-actualized.

88.

Fabrikant, Benjamin; Landau, Dale; and Rollenhagan, Jane. Perceived female sex role attributes and psychotherapists sex role expectations for female patients. ***New Jersey Psychologist*****, 23(2): 13-16, 1973.**

The authors report on their pilot study of therapists' role expectations for females. The sample of therapists was drawn from a current roster of a national organization of psychotherapists that included the disciplines of social work, medicine, and psychology. The authors note that younger therapists were underrepresented. All female members and a randomly selected equal number of males were asked to participate. Of the sample of 300, usable questionnaires were completed by 27 males and 37 females. Along with the therapists, a representative sample of 316 drawn from 741 male and 641 female respondents from the general population completed an adjective checklist of 100 words that described male and female characteristics. These respondents ranged in age from 15 to 55 and had between a high school and graduate education. The responses of the sample of psychotherapists revealed that male therapists were younger than the women; less likely to be single, divorced, or separated; and more frequently reported that their mothers and fathers made decisions jointly. The females were about evenly divided between masters' and doctorate level education, but most males were at the doctorate level or had a medical degree. The authors report that male and female therapists generally agreed to the following: women need not be married to lead a full life, marriage should be a coequal partnership, women cannot be completely satisfied or fulfilled in only the wife/mother role, a woman's sexual satisfaction is a necessary part of marriage, a woman can experience a fulfilling sexual relationship with someone other than her husband, a woman should exercise the freedom to choose life roles other than those of marriage and a family, women should have the primary responsibility for deciding whether or not a couple will have children, and day-care centers should be provided to free the woman for her choice of life style. Responses to the items that measured the therapists' view of the role of women as patients in psychotherapy indicated the following: male and female therapists agreed that the proper goal for a woman in therapy is to choose her own life style, male and female therapists encouraged their female patients to be less dependent on their husbands financially and socially, patients of male therapists were more likely than those of female therapists to complain about dissatisfaction with the role of wife/mother, male and female therapists felt that the wife should be dependent on the husband for sexual satisfaction, and female therapists felt that there is a difference in goals for the female patient based on the sex of therapist, although the male therapists did not feel this way. Both female and male therapists felt that female therapists were more effective with female patients. The authors note that although the psychotherapists indicated support for independence of choice by women in intellectual, social, and economic roles, they were less ready to accept a single standard of sexual activity for both men and women. The sample of 316 people who responded to the adjective checklist did not decide on a clear direction in the sex-relatedness of six of the words. The psychotherapists did not decide clearly on 24 of the 100 words. For both the general population and the psychotherapists, the adjectives chosen as descriptive of females were negative and those chosen as descriptive of males were positive. The authors conclude that further research is needed into the possible effects of these attitudes on the goals, especially those set by psychotherapists for female patients, and on the process and outcome of psychotherapy.

89.

Fabrikant, Benjamin. The psychotherapist and the female patient: Perceptions, misperceptions and change. In: Franks, Violet, and Burtle, Vasanti, eds. *Women in Therapy: New Psychotherapies for a Changing Society*. New York: Brunner/Mazel, 1974. pp. 83-109.

The author provides an extensive review of the literature on therapy for women and discusses major controversies (e.g., the feminists' criticism of Freud's theories about women). His own research focuses on the background, training and attitudes of therapists as they pertain to therapy with women. Thirty-one therapists and 50 of their patients (33 females and 17 males) responded to questionnaires. Twelve of the therapists were female and 19 were male. Therapists were drawn from a broad range of settings, including community agencies, feminist groups, and traditional clinics. They were questioned concerning the following: background; training, supervision, and experience as a therapist; current marital status and sex-role attitudes; views of marriage and female sex role; the role of women as patients in therapy; and the effectiveness of the therapist as a function of his/her sex. The patients responded to questions about background, experience as a patient, current marital status, perceptions of the therapist's sex-role attitudes and views of marriage, perceptions of the therapist's view of the role of women as patients in therapy, and perceptions of therapist's view of his/her effectiveness as a function of sex. Additionally, therapists responded to an adjective checklist according to how the words related to their own male and female traits, and patients were asked to respond according to how they perceived the therapist's rating of the same words. A comparison of male and female therapists revealed the following significant differences: the females were older, more frequently divorced or separated, less frequently held a doctorate, more frequently were in therapy, were in therapy longer, were more often very satisfied or very dissatisfied with their own marriage, and less frequently reported joint decision-making with a spouse. Significant differences between male and female patients were the following: females were older, less frequently had a college education, and were more often single, divorced, or separated. Both male and female therapists felt that marriage should be a partnership, although this attitude was not perceived by female patients, who thought the therapist's attitude was that the male should dominate. Compared with female patients and therapists, males more often felt that a majority of women can be satisfied and fulfilled by the wife/mother role, felt abortion should be a joint decision, viewed child rearing as a joint responsibility, and considered the male as the main provider. Several differences in the patients' view of the therapists' attitudes regarding sex are reported: females more often indicated that the therapist felt the same standards of sexual behavior should apply to both sexes, that husband and wife should have other sexual partners, and that the wife should not be totally dependent on the husband for sexual satisfaction. Males did not perceive the therapists' self-reported belief that females should be less dependent on males socially, though the females did. Female patients and therapists reported that male and female therapists differed in their goals for male and female patients; males did not report this difference. Female therapists and patients also perceived a tendency for male therapists to encourage female patients to be passive and male patients to be dominant; attitude measures of the patients and male therapists did not support this perception. The adjective checklist revealed that therapists and patients both had many stereotypes of sex-related characteristics, with male characteristics viewed as more positive than female characteristics. Many contradictions in this overall pattern are noted. The author concludes that the results are complex, confusing, and often contradictory; they fail to provide as clear a picture of one-sided bias as reported in the earlier studies cited. He suggests that the responses to the questions indicate a more liberal attitude toward females in both male and female therapists.

90.

Fischer, Joel; Dulaney, Diane D.; Fazio, Rosemary T.; Hudak, Mary T.; and Zivotofsky, Ethel. Are social workers sexist? *Social Work*, 21(6):428-433, 1976.

In this study addressed to the question of whether social workers are sexist, a questionnaire and a case study were mailed to 289 members of the Hawaii local chapter of the National Association of Social Workers. Of the 135 respondents, 79 were women and 56 were men. The proportions of respondents who were of each sex and who were married corresponded to those proportions in the organization's membership. The case studies described an individual with personal problems. Both the client's sex and the client's tendency to be aggressive or passive were varied in the case descriptions. Each responding clinician noted 11 judgments about the client on Likert-type scales. A three-way analysis of variance was used to analyze the relationship of the client's personality (aggressive or passive), client's sex, and clinician's sex to each of the clinical judgments. Findings significant at at least the .05 level are reported. Both the passive and the aggressive female clients were judged as being more intelligent, more emotionally mature, more in need of a permissive form of treatment, and more in need of encouragement to be expressive in treatment. Additionally, social workers were more positive in their attitude toward female than male clients. The sex of the social worker did not affect any but the last of these relationships; both males and females were slightly more positive in their attitude toward the same-sexed client. There was no significant interaction effect between the sex of the client and personality type. In a summary statement, the authors suggest that many of the findings reflect a bias that is positive toward women and negative toward men. There is no evidence that the pro-female judgments lead social workers to encourage more women than men to enter into therapy. Both of these conclusions are noted as contradictory to those of much research previously reported in the literature.

91.

Goldberg, Lorraine H. Attitudes of clinical psychologists toward women. (Abstract source, *Dissertation Abstracts International*, 35(B):1017-1018, 1974.) *Dissertation Abstracts International*. Ann Arbor, Mich.: University Microfilms, No. 74-16997. 245 pp.

The attitudes of 184 practicing clinical psychologists toward women and men were examined. A personal data sheet and a semantic differential attitude test were administered to these volunteer participants. The test was constructed to obtain measures of attitudes toward women and men in general, the mental health standards for men and for women and for adults in general, and attitudes toward men and women who need psychotherapy. Data were analyzed for the total group of subjects and for subgroupings. The subgroupings were determined by sex, age, and experience level in order to evaluate the effect of these three variables on the attitudes under examination. The results indicate a consensus among the subjects in regard to characteristics of women and men in general and the mental health standards appropriate for each sex. Additionally, both men and women were considered to possess approximately the same degree of the characteristics in the study, and the ideal mental health patterns for both sexes were basically alike. Goldberg reports that no markedly prejudicial sex-linked discriminatory attitudes toward the patients of these subjects were apparent. Generally, the results were applicable to all subjects, regardless of age, sex, or experience level. There were however, some significant differences in attitudes tested as a function of either the sex of the attitudinal object or the age, sex, or experience level of the subjects. Women therapists seemed to have more egalitarian attitudes toward men and women than men therapists; younger and inexperienced therapists were less likely to express a more traditional view of women; and older male therapists seemed to be somewhat more likely to exemplify traditional ways of thinking about women. Although these differences were statistically significant, they represent very small scale unit disparities, and their impact on behavior is unknown. Concluding that the attitudes of clinical psychologists toward women and men are complex and multidimensional, Goldberg recommends further investigation of the entire question, especially the behavioral manifestations of small, but significant, tested attitudinal differences.

92.

Gomes, Beverly, and Abramowitz, Stephen I. Sex-related patient and therapist effects on clinical judgment. *Sex Roles,* 2(1):1-13, 1976.

The authors hypothesized that how traditional a clinician's attitudes are toward sex roles and how conventional a patient's behavior is may be related to the clinician's judgments about the patient. A sample of 640 was drawn from the 1973 American Psychological Association Biographical Directory list of the members and fellows of Division 29 (Psychotherapy) who indicated that clinical practice was a main professional interest. The sample was stratified by sex. A total of 30 percent of the female therapists ($N = 96$) and 36 percent of the male therapists ($N = 114$) responded to a questionnaire. The sample size was further reduced by 15 male and 13 female respondents who indicated that the case information provided was not sufficient to allow them to make a clinical judgment. No response bias was found in the areas of age, years since Ph.D., size of community, or relative involvement in academic versus applied activities when 40 respondents were compared with 40 nonrespondents. Each subject received a set of 4-point Likert-type items that gauged impressions of a described patient, empathy of the therapist, attraction of the therapist to the patient, normativeness of the patient, and the "stereotypic sex-role manipulation." Five items from the Attitudes Toward Women Scale were also used. Four versions of a case history described the patient. The versions differed in their presentation of a cluster of traits and in the designation of a male or female patient. One set of traits had been designated as masculine in previous research, the other as feminine. The resulting categories of patient types were male role-appropriate, female role-appropriate, male role-inappropriate, and female role-inappropriate. A four-way analysis of variance (patient role, patient sex, therapist sex, therapist traditionalism) was carried out for each of the dependent variables, the therapist's judgment regarding normativeness, mental disorder, emotional maturity, social adjustment, prognosis, liking and empathy. An analysis of variance summary table which includes selected F statistics if provided. The study's most important finding was that the sex-role appropriate male was seen as more normative than the role-inappropriate female. Several statistically significant main and interaction effects are included in the summary table, but there was no clear pattern of any effect being significant across several types of judgment.

93.

Haan, Norma, and Livson, Norman. Sex differences in the eyes of expert personality assessors: Blind spots? *Journal of Personality Assessment*, 37(5):486-492, 1973.

A study of the effect of therapist sex on personality assessments was conducted. The therapists were 23 (10 male and 13 female) experienced, Ph.D. level psychologists who had made judgments about the personalities of 171 clients. Among the 171 clients, there was a subsample of 48 men and 50 women whose evaluation happened to be done by at least one male and one female psychologist. Interview material with clients was quantified by the psychologists with the California Q Sort, which consists of 100 personality descriptive items. A comparison of the judgments of all of the clients by all of the therapists showed that the psychologists' comprehensive views of the clients of both sexes were not a function of therapist sex. When judgments of male and female psychologists about the subsample were compared, overall assessments were the same. However, specific characteristics were judged differently by the two sexes. Major findings regarding the judgment of female clients were the following: (1) women psychologists saw female clients as more intellectually competent and self-accepting than did male psychologists; (2) women judges gave greater saliency to control dimensions (e.g., self-dramatization, over-control); and (3) men judges perceived women as more conforming with sex-role stereotypes (e.g., insightful) and as expressing more aggression and uncertainty than did women psychologists. Several findings pertinent to the judgment of male clients were also reported. Women psychologists perceived proportionately more bad than good characteristics of male clients, but not of female clients. Male psychologists emphasized bad characteristics of both men and women clients. Other findings suggest that men psychologists were most sensitive to males' variations from the male stereotype, while women were most aware of "excesses" of males in conforming to that stereotype. Similarly, women psychologists seemed to focus on unfavorable excesses in females of female stereotypic traits (e.g., self-dramatization), while male psychologists focused on females' failure to live up to the stereotype of a "good woman" (e.g., bitchiness). Overall, male psychologists were more negative than female psychologists in their view of both sexes. The authors consider their findings as evidence that highly trained psychologists exhibit less sex-related bias than others in this society. They caution that it is important to determine whether men or women provide the most accurate judgments of clients' personalities.

94.

Harris, Linda Hall, and Lucas, Margaret Exner. Sex-role stereotyping. *Social Work*, 21(5):390-395, 1976.

Harris and Lucas report on their investigation of the influence and extent of sex-role stereotypes in potential mental health professionals. An inventory of 82 bipolar (masculine-feminine) items, 38 of which had been identified as stereotypic, was given to 345 undergraduate and graduate social work students (26 percent male). Subjects were randomly assigned to three groups and asked to make hypothetical ratings for either (1) a mature, healthy, socially competent person, (2) a healthy adult male, or (3) a healthy adult female. The authors report that there were no significant differences among ratings made by the three groups. However, male subjects rated a healthy man closer to the stereotypical masculine pole than a healthy woman, and female subjects rated a healthy woman as more masculine than a healthy man. Undergraduate students' responses showed a tendency toward a biased perception of mental health as compared to graduate students, indicating that stereotypes are not static. The authors point out that the results indicate a possible trend toward less sex-role stereotyping among potential mental health professionals, with women changing their views more rapidly than men, although differences may result in part from subjects' reluctance to openly endorse traditional stereotypes. They discuss the need for further research in the area of sex-role stereotyping in order to determine the degree of observed attitudinal changes.

95.

Johnson, Patricia I. The relationships between sex-role stereotypes and concepts of mental health. (Abstract source, *Dissertation Abstracts International*, 34(B):5195, 1974.) *Dissertation Abstracts International*. Ann Arbor, Mich.: University Microfilms, No. 74-8969. 98 pp.

In this investigation of the stereotypic attitudes of mental health professionals, a shortened version of the Stereotype Questionnaire was completed by male and female psychiatrists, social workers, psychologists, and counselors under four stimulus conditions: well-integrated female, poorly integrated female, well-integrated male, and poorly integrated male. Johnson reports significant differences between the means for these four conditions. The well-integrated male and female ratings were in the direction of the male stereotype. In contrast, the poorly integrated male and female ratings were in the direction of the female stereotype. Male and female subjects basically agreed in their ratings of the four conditions, with one exception. Female subjects rated the poorly integrated female significantly more in the direction of the feminine stereotype than did male subjects. The strong trend toward differences in the way the four professional groups completed the questionnaire was attributed mostly to the female conditions. The author concludes that inappropriate sex-role behavior is interpreted as "mentally sick" for males only. It appears to her, therefore, that the female stereotype and "mental illness" are very closely related. A discussion of suggestions for future research is included.

96.

Libbey, Mary Durgin. Sex-stereotyping in psychotherapist responses in an analogue therapy situation. (Abstract source, *Dissertation Abstracts International,* 36(B):1441, 1975.) *Dissertation Abstracts International.* Ann Arbor, Mich.: University Microfilms, No. 75-18407. 143 pp.

Libbey investigated the sex-stereotyped behavior of 30 male and 30 female psychodynamically oriented psychotherapists in response to two staged tapes of male and female client talk as a function of client sex and therapist sex. She hypothesized that the therapists, regardless of sex, would respond with more (1) expression of positive emotion and (2) specificity toward female clients than toward male clients and with more (3) confrontation toward male clients than toward female clients. These dimensions were assumed to be a function of the cultural tendency for women to be seen and responded to as more expressive of positive emotion, more dependent, and more in need of structure than males, whereas men are perceived as more "mentally healthy" and responded to with more of a demand to think than females. An analogue therapy procedure was used to measure therapist behavior. Scripts of two neurotic clients were recorded onto tapes, once as a male and again as a female. The therapists were divided into two groups, with half listening and recording responses to Male Abrams and Female Brown and half listening and recording responses to Female Abrams and Male Brown. The therapists' responses were rated with three high-low scales (developed by Libbey) of the dimensions under study. The expectation that all therapists would react in stereotyped ways was not supported. Only one hypothesized result occurred, and that only partially. In response to the Brown clients, all therapists responded with a greater degree of positive emotion toward the female version than toward the male version. Partial findings occurred in the varying use of the behaviors under study as a function of therapist sex. In response to at least one of the two scripts, female therapists used a greater and seemingly more optimal degree of each behavior than male therapists. In no case did male therapists use a greater degree of behavior, i.e., expression of positive emotion, specificity, or confrontation, than female therapists. When responses toward the male and the female clients were looked at separately, there was a greater use of each behavior by female therapists in response to the male clients. No differences occurred between therapists in response to female clients. Libbey suggests that the hypothesis may not have been supported because of the high expertise of the therapists used as subjects and because the scales were not sufficiently refined to pick up the subtleties of sex stereotyping. In conclusion Libbey notes that it may be that therapist sex is a somewhat better predictor of therapist behavior than is a sex stereotype.

97.

Maslin, Audrey, and Davis, Jerry L. Sex-role stereotyping as a factor in mental health standards among counselors-in-training. *Journal of Counseling Psychology*, 22(2):87-91, 1975.

According to the authors of this article, a counselor's expectations that a healthy adult female will differ from a healthy adult and/or a healthy adult male may limit the female's achievement of her full potential. In research conducted to investigate the possibility of counselor bias, a stratified sample of 45 males and 45 females was randomly selected from the total number of full-time students in the counseling program at Temple University. Twenty-two of the students were in the doctoral program and 68 were in the master's program. A shortened version of the Stereotype Questionnaire (Rosenkrantz et al. 1968) was administered to the students. Of the 82 questions asked, the responses to 38 items previously established as sex stereotypic among male and female college students are analyzed in this article. Subjects were randomly assigned to receive one of three versions of a request for their choice on 38 bipolar items of what they would expect a "healthy, mature, socially competent" person to be like. The versions differed in their identification of the person as "adult male," "adult female," or simply "adult." Each scale ranged from 1 to 7, which corresponded to a rating of extremely stereotypic feminine behavior to extremely stereotypic masculine behavior. An average mean score was obtained for the six groups of respondents. There were no significant differences in the group means for males and females who received the "adult" version or in those for males and females who received the "adult male" version. In the group of respondents who received the "adult female" version, males had a significantly lower group mean than females ($p < .01$), i.e., their ratings were more stereotypically feminine. An additional finding was that females do not differ significantly in their expectations of various kinds of healthy persons, and that males had a significant tendency ($p < .05$) to report stereotypic expectations of females. Maslen and Davis stress that the difference between males' and females' expectations for healthy female adults does not replicate the results of similar research (Broverman et al. 1970). They suggest that the use of slightly different scoring methods, sampling methods, and statistical analysis may account for the difference. Also noted is the possibility of the effect of historical change, i.e., in the time period between the two studies support has grown for the women's movement and its egalitarian beliefs. If this latter explanation were accurate, it would suggest that the females in this sample have stopped using stereotypes in their images of healthy women but that males continue stereotyping to some degree.

98.

Miller, Donna. The influence of the patient's sex on clinical judgment. *Smith College Studies in Social Work*, 44(2):89-100, 1974.

The problem addressed in this study is whether the patient's sex affects clinical impressions formed by mental health professionals. The study sample included 67 psychiatric social workers and social work students who were the majority of the staff at a teaching hospital, 65 senior and resident psychiatrists who were the majority of the residents and staff psychiatrists at the hospital, and the 18 psychologists and psychological interns at the hospital. From this sample 6 male social workers and 33 female social workers, 1 male psychologist and 5 female psychologists, and 22 male psychiatrists agreed to participate in the study. A case analogue which depicted a white, Protestant, 26-year-old, single individual who had psychosomatic complaints and suffered from mild depression was presented to each professional. The analogue stressed that the patient was extremely passive. Approximately half of each of the professional groupings received a version of the analogue which identified the client as a male, while the others received a version in which the client was a female. Professionals were asked to respond to questions designed to measure their impressions of the adequacy of the patient's functioning in 14 areas as well as to give their assessment of their own capacity to empathize with the patient and of the patient's likelihood of offering interfering transference. Respondents were also asked to indicate the goals of treatment, to predict the amount of change that would occur in six areas, to place the patient in one of six diagnostic categories, to choose a level of treatment between supportive or interpretive, and to rank five problem areas in order of importance. For 11 areas of patient functioning, the author reported that the female form elicited slightly more favorable responses than the male form and that "a sign test revealed that this pattern was statistically significant ($p < .05$)." The author presents a table of the frequency with which each diagnostic classification was chosen for the male and the female patient and notes that the female tended to be judged as healthier than the male. Based on a table of the ranked value of the patient's major difficulties, the author also concludes that there were no differences for the male and female patient. A chi-square analysis of the frequency with which five areas were designated as the central focus of treatment revealed that there was a significant difference in the choice of focus for the male and the female patient. Passivity tended to be chosen as the focus more often for the male than for the female. There were no reported differences in judgments of the patient's probable gain in treatment, or the professional's assessment of his/her ability to empathize with the patient, between male and female patients. The professionals did expect more interfering countertransference with the male than with the female patient ($p < .02$). According to Miller, the only difference between professional groupings was that social workers tended to recommend supportive treatment more frequently than psychiatrists and psychologists. Within the group of social workers supportive treatment was chosen instead of interpretive, insight-oriented services more frequently for female patients; chi-square analysis revealed that this difference was significant ($p < .02$). The author concludes that the sex of the patient influences clinical judgment slightly but significantly. She emphasizes the finding that passivity was considered less problematic for the female patient than for the male, and she calls for studies that would examine professional judgment of a number of different types of cases.

99.

Moore, Martha Holderman. The modification of sex-role stereotypes held by counselor trainees. (Abstract source, *Dissertation Abstracts International*, 34(A):3066, 1973.) *Dissertation Abstracts International*. Ann Arbor, Mich.: University Microfilms, No. 73-23869. 150 pp.

In this study the sex-role stereotypes held by 20 male and 20 female counselor trainees were measured, and an effort was made to modify these stereotypes using an educational treatment. An equal number of males and females were assigned to an experimental group and a control group. The experimental group received a booklet of readings on sex-role stereotypes and participated in two discussion group sessions on these readings. The control group was given a booklet of readings on contemporary issues in counseling which excluded any reference to sex-role stereotyping. This group also participated in two discussion group sessions that focused on their readings. Following the Solomon Four Group Design, one half of the experimental group and one half of the control group received the pretest. All subjects were administered the Sex-Role Questionnaire and the Sex-Role Survey at the posttest. Four weeks later a post-posttest was administered to all subjects. An analysis of variance for each of the 33 stereotypic items on the Sex-Role Questionnaire showed no significant results for 17 items. Sex differences accounted for many of the results on the significant items on the Sex-Role Questionnaire. No significant results were found on the Sex-Role Survey. Moore indicates that females in both the experimental and control groups held less rigid sex-role stereotypes than male subjects in the two groups. Concluding that little significance was due to the experimental treatment, Moore makes recommendations for further research in the area of sex-role stereotyping.

100.

Neulinger, John; Stein, Morris I.; Schillinger, Morton; and Welkowitz, Joan. Perceptions of the optimally integrated person as a function of therapists' characteristics. *Perceptual and Motor Skills*, 30(2): 375-384, 1970.

This study attempted to determine whether there is a consensus for the concept of mental health. Seventy-four male and 40 female psychotherapists were questioned about the "optimally integrated" male and female. The relationships between the personality profiles and three variables—school of psychotherapy, psychotherapist sex, and client sex—were analyzed. The possible effects of length of psychotherapeutic experience, professional discipline, and therapist age were also examined. The data on 114 United States psychotherapists were compared to data collected from 50 Czechoslovakian psychotherapists. The professional disciplines of the U.S. therapists were represented by 19 psychiatrists, 85 clinical psychologists, and 10 social workers. The schools of psychotherapy the therapists identified themselves with included Freudian, Neo-Freudian, Sullivanian, Behaviorist, and other diverse orientations. Data were collected with a mailed questionnaire that required respondents to rank the needs (as described in paragraphs based on the Murray et al. (1938) need system) of an optimally integrated person. The U.S. therapists performed this task for both a male and female; the Czechoslovakian therapists described a person whose sex was unspecified. Differences in perceptions of the needs of optimally integrated people were tested with the analysis of variance procedure. Findings ($p < .05$) and trends ($p < .10$) are presented. Freudians perceived Autonomy as less characteristic and Harm avoidance as more characteristic of males than did the Neo-Freudians. Freudians also ranked Deference as more characteristic of males, and tended to see the need for Autonomy as less characteristic of females, than did either the Neo-Freudians or the Sullivanians. There was a trend for the Behaviorists to rank Defendance as more characteristic and Succorance as less characteristic of males than did the Freudians or the Sullivanians. Freudians are reported to perceive the need for Autonomy as less characteristic of females than did Neo-Freudians or Sullivanians ($p < .05$). A trend is noted for Neo-Freudians to regard Succorance as less characteristic of females than did Freudians and Sullivanians. There was also a trend for Behaviorists to rank Defendance as more characteristic of the well-integrated female than did the other schools. For both males and females, female therapists reported that Achievement was more characteristic of the well-integrated person than did the male therapists. Also, female therapists found Abasement less characteristic of females than did male therapists. For males, psychiatrists ranked Harm avoidance as more characteristic and Dominance as less characteristic than did Ph.D. psychologists. For the female, psychiatrists ranked Harm avoidance as more characteristic and Autonomy as less characteristic than did the psychologists. Correlation analysis showed that for the male, the older the therapist, the lower was Harm avoidance placed as a common characteristic. Regarding the female, the older the therapist, the higher were Achievement and Aggression placed and the lower was Sentience ranked as a common characteristic. For the female, the more experienced therapist placed Aggression higher in the hierarchy of needs than the less experienced therapist. Results are presented for the Czechoslovakian sample. The authors conclude that there are relatively few differences within the United States, particularly in comparison to differences between the U.S. and Czechoslovakian samples. They consider the major finding to be female therapists placing Achievement higher than male therapists for both the male and the female optimally integrated person.

101.

Schwartz, Joseph M., and Abramowitz, Stephen I. Value-related effects on psychiatric judgment. *Archives of General Psychiatry*, 32(12):1525-1529, 1975.

An experiment was conducted to explore the effect of patient's sex and race on the clinical judgments of psychiatrists. A sample of 491 subjects was randomly selected from the 1968 edition of the *Autobiographical Directory of the American Psychiatric Association*, Twenty-one percent (102) of the psychiatrists returned a research booklet in which they recorded their clinical inferences and their own demographic characteristics. Questions in the booklet referred to a case description of a patient. The sex and race of the patient were systematically varied. Patient sex and race were crossed with psychiatrist experience (more versus less) and psychiatrist traditionalism (more versus less) in a factorial design. The prominent symptoms included in the case description were depression, somatic complaints, sexual conflicts, and overdriven perfectionism. The authors report a statistically significant effect of patient sex on the psychiatrist's judgment of the patient's sex-role normativeness—the female-designated material was perceived as more sex-role congruent than the male. The interaction of sex and race was also found to be statistically significant, with the behavior viewed as more normative for black than for white women. A number of variables related to patient's race and psychiatrist's traditionalism had a statistically significant effect on treatment recommendations. Traditional psychiatrists recommended dynamic therapy less often for men than women; less traditional psychiatrists offered women less insight-oriented therapy than men; and both traditional and nontraditional psychiatrists recommended more insight-oriented therapy for white than black men, although this difference was not found for women. Prognostic inferences were significantly related to practitioner experience. White women received relatively poor prognoses from the more experienced psychiatrists. Women were perceived as better candidates for drug therapy by the more experienced practitioners. Finally, black female patients received higher attraction ratings than male or white patients. The authors conclude that there is not a simple psychiatric bias against black or female patients. Their findings regarding sex-related bias illustrate that these biases are mediated by clinicians' sociopolitical beliefs. They also note that experience does not result in decreased bias. In conclusion, there is a brief discussion of bias introduced by the respondent's attempt to provide socially desirable answers in the research booklet.

102.

Sherman, Julia; Koufacos, Corinne; and Kenworthy, Joy Anne. Therapists: Their attitudes and information about women. *Psychology of Women Quarterly*, 2(4):299-313, 1978.

The authors surveyed 184 therapists to obtain therapist information about women and therapist attitudes toward women. They describe the Therapists' Information about Women Scale and the Therapists' Attitude toward Women Scale, which they developed for use in the survey. The sample included social workers, psychologists, and psychiatrists—approximately one fourth of all therapists in Wisconsin who were listed with a professional organization. Twenty-nine percent of the therapists responded to a mailed questionnaire, with a higher proportion of women than men in each profession responding. Male psychiatrists responded the least frequently. The authors suggest that an additional response bias was that respondents tended to be more liberal and less stereotypic than nonrespondents. An analysis of variance performed on the scores from each scale found no significant differences between professions but did find significant sex-related differences. Female therapists were better informed, more liberal, and less stereotyped in their views than male therapists. For example, females knew more than males about the psychology of female bodily functioning; they also knew more about recent research on the psychology of women. Males reported many contradictory role expectations for female clients. Additionally, male attitudes toward female frigidity, goals in therapy, and abortion reflected a stereotypic view of women. Male therapists, significantly ($p < .05$) more often than female therapists, thought "one of the most important goals of therapy is to get the client to adjust to her circumstances." A small proportion of male therapists sanctioned sexual relations between client and therapist. Included in the questionnaire were open-ended questions about why more females than males were in therapy, how therapists thought the sex of therapist might influence therapy, the extent to which therapists see a need for lesbian clients to change their sexual preference, therapists' suggestions for training programs, their perception of a need for special training to work with women, and recommended reading to other therapists for work with women. Frequencies of various response categories are presented. The authors emphasize that there is a need for special training for therapists to work with female clients. They conclude that contrary to Stricker's (1977)* "specious and misinformed" assertions, the results of this study are "clearly consistent with the conclusion that sex bias and sex-role stereotyping are not uncommon in psychotherapeutic practice and are more likely to be found among male than female therapists."

103.

Stricker, George. Implications of research for psychotherapeutic treatment of women. *American Psychologist,* 32(1):14-22, 1977.

Stricker writes that there is only analogue data, not direct evidence, concerning the treatment of women in psychotherapy. He focuses on two areas that possess a potential for findings of sexism in treatment—sexual relationships between therapists and patients and the possible imposition of growth-stultifying sex-role stereotypes on females by their therapists. Stricker considers it to be of particular relevance that most incidents of sexual relations involve male therapists and female patients, and he asserts that such relations are always inappropriate, exploitative, unethical, of no psychotherapeutic benefit, and potentially destructive. Maintaining that well-designed field studies are necessary if definitive conclusions concerning sex bias in psychotherapy are to be reached, Stricker continues with a critical discussion of analogue studies in which therapists were asked to evaluate the adjustment of either females in general or female patients. He describes, questions, and presents conclusions from the studies of Neulinger (1968),

*See abstract following.

Neulinger et al. (1970), Haan and Livson (1973), Abramowitz and Abramowitz (1973), Abramowitz et al. (1973), and Thomas and Stewart (1971). The studies of Broverman and her associates are identified as particularly important because of their very wide citation in the research literature and the popular press. After discussing the widely used sex-role stereotype questionnaire developed by Rosenkrantz et al. (1968), Stricker challenges the conclusion of Broverman et al. (1970) that clinicians are more likely to suggest that healthy women differ from healthy men on such items as submissiveness, independence, etc. He points out that there is no indication that the actual differences are statistically significant, since no analysis of individual items was provided. Regarding the conclusion that a double standard of mental health exists, Stricker emphasizes again that no analysis of individual items was presented and, consequently, the value of the finding that there was a significant difference between the scores of females and adults but no difference between the scores of males and adults is reduced. The data of Fabrikant (1974)—initially in essential agreement with the findings of Broverman et al. and subsequently indicating a tempering of the extent of sexism—are identified as insufficient for adequate evaluation and critique. According to Stricker, the data, which show high correlations between rankings of males and females and few statistically significant differences, do not support the conclusion that male therapists impose undesirable and demeaning stereotypes on their female patients. Making reference to the work of Steinmann (1974), he attempts to explain the reasons behind these frequently drawn, quoted, and unsupported conclusions. Presenting analogue studies conducted by two of his students, Oppedisano-Reich (1976) and Maxfield (1976), Stricker expresses his agreement with Maxfield, who reported as the major implication of his study that there is no overall bias against women by either men or women psychotherapists. After criticizing the American Psychological Association's Report of the Task Force on Sex Bias and Sex-Role Stereotyping and their conclusion that a double standard of mental health exists among psychologists, Stricker concludes that (1) sexual relations between patient and therapist do exist and are a blatant example of sexism and exploitation in psychotherapy; (2) the sex of the therapist per se is of little consequence with regard to sexist practice, for it appears that whatever bias occurs is equally distributed between the sexes; (3) presently there is insufficient evidence for the widely cited conclusions concerning a double standard of mental health and negative evaluations of women; and (4) sex-role stereotyping is widespread in our society but is more likely to occur when generic groups, such as women or patients, are rated and least likely to occur when specific individuals are rated. Stricker offers some recommendations for action.

Effect of Sex of Client/Therapist on Process and Outcome of Therapy

104.

Abramowitz, Stephen I.; Abramowitz, Christine V.; Roback, Howard B.; Corney, Robert T.; and McKee, Embry. Sex-role related countertransference in psychotherapy. ***Archives of General Psychiatry*****, 33(1):71-73, 1976.**

Responding to recent recognition of the political implications of mental health practices and the political context in which therapy occurs, the authors focus their study on the effect of sex-role ideology on countertransference in psychotherapy. They investigated the differences between male and female therapists in their freedom to allow the arousal of their own sexual curiosities by patients, as indicated by a tendency for the therapist to extend contact with opposite-sexed patients. The researchers expected male therapists to be freer to allow the arousal of sexual curiosities than female therapists who "may avoid professional assignments whose contemplation activates strong superego controls over sexual expression." Assignments that activated strong superego controls were defined by the researchers as those that involved a divorced or single male client. Data were gathered from the files of one psychologically and one psychiatrically oriented agency where therapists were reported to exercise "reasonable autonomy over case selection." One-hundred and sixty clients of the psychologically oriented agency were offered counseling beyond standard intake and assessment interviews by 23 male and 11 female predoctoral trainees in clinical and counseling psychology. Similarly, the researchers obtained data describing 160 different clients who were offered therapy at this psychologically oriented facility by 6 male Ph.D. level psychologists. A third set of data on 156 clients who were seen by 1 female and 8 male second year psychiatric residents and 2 females with a Masters in Social Work degree was obtained from the psychiatric agency. A chi-square analysis provided evidence that at the psychological agency the male predoctoral therapists saw female patients more frequently than they saw male patients ($p < .02$). This trend is reported to be evident but not significant at the psychiatric facility ($p < .20$). There was no significant association between client's sex and frequency of treatment at either agency when the therapist was a female. For the group of doctoral level psychologists, higher levels of experience in therapy were associated with a higher proportion of females in the clinician's caseload ($p < .02$). Compared with male therapists, females saw fewer sexually uncommitted clients. A status of being single or divorced was used to indicate lack of sexual commitment. The remainder of the reported analysis is limited to an examination of the behavior of just the female therapists. At both facilities female therapists chose female clients more often than male clients ($p < .07$ in each case). The authors interpret the finding that the one married female therapist saw proportionately more male patients than did the two unmarried female therapists as evidence that the single female therapists "may have been compensating for their sexuality availability." They further report that among the clients seeing female therapists, the older and less well-educated men received the least amount of treatment. The one married female therapist saw three male and one female uncommitted clients while the two single therapists saw no male and 12 female uncommitted patients, which the authors again view as suggesting that unmarried females avoid unmarried male patients. The authors note that the fact that the married female therapist was a psychiatric resident and the single female therapists were psychiatric social workers may result in the confounding of type of training with marital status of the therapist. Based on the study, the authors conclude that "female therapists [may be] more sensitive than men to superego strictures regarding sexual arousal" and that voyeurism is "an almost exclusively male pastime."

105.

Alexander, James F., and Abeles, Norman. Psychotherapy process: Sex differences and dependency. ***Journal of Counseling Psychology*, 16(3):191-196, 1969.**

The authors, who believe the effect of client sex on client dependency in psychotherapy has been neglected, examine the verbal dependency of male and female psychotherapy clients, as reflected in their discussion of several interpersonal relationships. One of these relationships was the interaction with the therapist. The clients included 10 males and 10 females who had voluntarily requested counseling at the Michigan State University counseling center and agreed to have therapy sessions tape recorded for a library that was maintained by the counseling center. All of the clients were undergraduate students who desired counseling for personal and social problems. They were seen by 4 Ph.D. level psychologists and 11 advanced doctoral candidates in psychology, all male. Fifteen-minute segments of the tape recording of the first, middle, and last psychotherapy session were randomly selected. Three raters scored each client statement that was made during the selected segments to reflect content, the relationship involved, and internal versus external focus. Subsequent therapist responses were coded to indicate approach versus avoidance behavior, the relationship involved, and internalization versus externalization. Intercoder reliability was between .80 and .96 for the various measures. No significant difference between male and female clients was found in their expression of dependency with the therapist, or in any other type of relationship considered in the study. Subgroups of females and males were formed by matching clients on number of deviant scores ($p > 70$) and on Mf (Masculinity-femininity) scores. Within these subgroups, there were no significant differences in dependency as mentioned by males or females in various relationships. Thus, the study did not support the initial hypothesis that males were less dependent in psychotherapy, and in other relationships, than females. The authors suggest several alternative hypotheses: (1) therapists may perceive male and female dependent behavior differently; (2) the measure of dependency may be confounded with another variable; (3) intensity of comments about dependency may be a better indicator than frequency of comment; or (4) male and female clients in a university counseling center may differ less than males and females in other settings in the dependency that they experience in various relationships.

106.

Brooks, Linda. Interactive effects of sex and status on self-disclosure. *Journal of Counseling Psychology*, 21(6):469-474, 1974.

Brooks identifies client self-disclosure as a major factor in process and outcome of therapy, indicating that sex of client and therapist and therapist status have been suggested to be related to the amount and nature of self-disclosure. To investigate the interactive effects of these variables, she randomly assigned 40 male and 40 female single undergraduates aged 18-25 to two male and two female doctoral counseling students. Clients had no counseling experience and no preference for sex of counselor. Each counselor was assigned five male and five female clients for both status conditions.

Status was manipulated by briefing, by statements made by the counseling center receptionist, and by the appearance of counselors' offices. The interview format was standardized and involved the use of reflective statements. The Revealingness Scale (Suchman, 1965) was applied to two 3-minute taped segments of each interview by one male and one female graduate student, blind to experimental conditions. Clients evaluated the interview on the Counselor Evaluation Inventory (Linden et al. 1965); they also rated interviewer's experience on a 5-point scale and responded to an open-ended question about the status briefing. Responses to the last two items indicated that the status manipulation was effective. Brooks reports that there were significant interactions between subject sex and both interviewer sex and status ($p < .05$). Clients disclosed more to opposite-sex counselors, and disclosures were highest in dyads containing a female in either position. Males disclosed more in high status conditions and females in low. Within status conditions, self-disclosures varied as a function of sex: in high-status conditions, subjects disclosed more to male interviewers, and in low status, disclosure was higher with female counselors. The Counselor Evaluation Inventory scores showed significant interactions between interviewer sex and status. Brooks indicates that the hypothesis—there would be more disclosures in dyads containing a female—was supported, but predictions that female clients would be more self-disclosing and that high status would lead to an overall increase in self-disclosure were not. Brooks suggests that self-disclosure may be facilitated by assigning opposite-sex pairs, by maximizing status of male counselors with clients of both sexes, and by maximizing status of all counselors assigned to male clients.

107.

Cartwright, Rosalind Dymond, and Lerner, Barbara. Empathy, need to change, and improvement with psychotherapy. *Journal of Consulting Psychology*, 27(2):138-144, 1963.

The authors investigated the impact and interaction of five factors that have been hypothesized to be related to improvement in therapy—sex of therapist and patient, patient's need to change, experience level of therapist, distancing between therapist and patient, and therapists' empathic understanding of patients. Improvement of 28 patients, 14 female and 14 male, ranging in age from 19 to 43, who had voluntarily sought the client-centered counseling offered at the University of Chicago was assessed by pre- and posttherapy ratings of their integration, their defensive versus open organization, and present life adjustment. The 16 therapists also rated patients' improvement. The Kelly Role Construct Repertory was used to devise scales of empathic understanding and need to change. The authors report that need to change and empathic understanding were both significantly related to improvement. They found that length of therapy was also related (though not significantly) to improvement, with fewer interviews for more improved clients. A prediction model for therapy length and success was produced by patient's need and therapist's empathy considered together. Therapists had significantly higher pretest empathy scores with opposite sex patients, but the difference did not hold over time. Therapists also reduced distance with same-sex patients and increased it with opposite-sex patients at first testing. Early in therapy, therapists tended to see same-sex patients who improved as being like them and opposite-sex patients who improved as being very different. Inexperienced therapists tended to see patients as being less like them than patients' ratings indicated. The authors point out that the results describe two groups with a high likelihood of success in therapy: same-sex patients of experienced therapists who early reduce the distance between themselves and the patient, and opposite-sex patients of inexperienced therapists who initially increase distance.

108.

Davidson, Virginia. Patient attitudes toward sex of therapist: Implications for psychotherapy. In: Claghorn, James L., ed. *Successful Psychotherapy*. New York: Brunner/Mazel, 1976. pp. 155-169.

Davidson initially reviews the literature to demonstrate the paucity of research on how the variable of sex, of patient or therapist, relates to the process and outcome of therapy. She suggests, however, that the situation may be changing as a result of the women's movement and the attention it has directed to women's therapy. Davidson discusses the effects patients' perceptions of therapists' sex roles have on women psychotherapists and examines the data from the one published study (Chesler, 1971), which she suggests does not support the claim that psychotherapy patients prefer male therapists. Thereafter, the author focuses on her own study. Over 10 consecutive months in 1973-74, the 272 applicants to an outpatient middle-income psychiatry clinic—two thirds female, predominantly white (although blacks, Mexican-Americans, and other ethnic groups were included in the sample), and with an age range of 14 to 68—completed a questionnaire as part of their registration. They were requested to indicate preference, or no preference, for ethnicity and sex of therapist. If a preference was indicated, the patients also completed a checklist of the qualities they assumed would be associated with the therapist of the preferred sex. Of those who indicated a sex preference, male therapists were preferred 2:1, and this ratio held for both the male and female sample populations. The young respondents were more likely to express no sex preference and were the group most likely to prefer female therapists when they did have a preference. The marital status of the respondents was the category that showed the most striking variation in preference for therapist by sex. Males in the widowed-separated-divorced category showed a greater preference for male therapists. Female respondents were more likely to prefer a therapist of the opposite sex when they were single or in the widowed-separated-divorced category. Davidson suggests that patients in different marital categories may have differing therapeutic needs or at least have the strongest response to the sex of the therapist. "Feeling comfortable" and being able to "talk freely" were the only reasons checked for preference of sex by more than 50 percent of the respondents of both sexes. When the reasons for their preferences were controlled for sex of respondent, "feeling comfortable" did not change much, but women preferring male therapists checked "talking freely" less than women preferring female therapists, suggesting that these two groups of women had different reasons for their preferences. "Understanding my problem" was frequently checked by women seeking women therapists, while women seeking male therapists did not rate "understanding" as an important expected characteristic of the male therapists. Individuals of both sexes expected to be able to "talk more freely" with a therapist of the same sex. The author suggests the possibility that female therapists are perceived by patients as possessing different personality characteristics than their male counterparts. It is time, she concludes, for psychotherapy literature to reflect the existence of two sexes and the effects of this on therapy.

109.

Doherty, Edmund G. Therapeutic community meetings: A study of communication patterns, sex, status, and staff attendance. *Small Group Behavior*, 5(2):244-256, 1974.

Patient sex has recently become a variable of concern in study of the structure and process of psychiatric treatment. The present study was concerned with the question of the effects of patient sex, staff status, and staff-patient ratio on communication patterns in therapeutic community meetings. The six groups of subjects consisted of 6 psychiatrists and residents, 5 social workers, 5 nurses, 9 aides, 25 male patients, and 19 female patients. Meetings were conducted daily in a private psychiatric hospital with a therapeutic community approach. A nonparticipant observer recorded verbal communications and categorized them on a "who-to-whom" basis for the six subject groups plus a category for "the community as a whole." Data were collected 2 weeks before, during, and after the number of staff members attending meetings was halved. The author reports his finding that male patients first, then physicians, participated significantly more often than all other groups. Physicians significantly more frequently directed their comments to male patients, then to the community group, and to female participants; nurses significantly more frequently addressed male patients, then female patients, and the community group. The most frequent recipient of male patients' verbal communications was the community, followed by physicians and other male patients. Women patients spoke significantly more frequently to male patients and physicians than to others and tended to ignore other women patients. Physicians and nurses increased communication during the staff reduction period. Male patients spoke more before the staff reduction period, next most during the reduction, and least after the staff reduction period. Other groups did not change. Thus, females in a therapeutic community meeting spoke less than men and directed their comments more often to male patients and physicians than other groups. The author relates that sex-linked communication also prevailed among the staff but was confounded by status differences, since all the physicians were male.

110.

Felton, Gary S., and Biggs, Barbara E. Psychotherapy and responsibility: Teaching internalization behavior to black low achievers through group therapy. *Small Group Behavior*, 4(2):147-155, 1973.

The authors investigated the degree to which internalization—a change toward an internal locus of control—can be taught in intensive short-term group psychotherapy. Subjects were seven male (mean age 19.4) and eight female (mean age 19.0) black students in the Los Angeles Student Development Center for underachievers; nine black freshmen women (mean age 18.8 years) students in a traditional college program on the same campus served as a comparison group. Experimental subjects were tested on the Rotter Internal-External Scale before and after 40 group therapy sessions and 1 encounter weekend; controls were given pre- and posttests but no therapy. On pretest, female subjects' scores indicated more externalization than males. No significant pre- to posttest changes were found in the comparison group, whereas the experimental group had significant decreases on Internal-External Scale scores, indicating greater internalization, Women's scores indicated greater changes toward internalization than men's, and experimental female subjects' scores changed significantly more than comparison subjects'. Thus the significant change toward internalization in the experimental group derived primarily from the large changes in female subjects. Because there was a trend for experimental female subjects to score higher on internalization after therapy than comparison college student subjects given no therapy, results indicate that preceived responsibility for behavior can be shifted in group psychotherapy. It has been suggested that females' higher externality may be related to a perception of powerlessness, which can be changed through appropriate learning in therapy. The authors describe the teaching methods that were used and note that the change toward an internal locus of control is related to success in therapeutic and academic ventures.

111.

Fuller, Frances F. Influence of sex of counselor and of client and client expressions of feelings. *Journal of Counseling Psychology*, 10(1):34-40, 1963.

The author hypothesized that females in counseling would express more feeling than males regardless of sex of counselor and that male clients would express more feeling with male counselors. Subjects were 32 (16 male and 16 female) university counseling center clients—half of the subjects preferred male counselors and half had no preference. Clients had either educational or vocational presenting problems and were seen initially by a male intake counselor. Subsequent sessions were with eight counselors balanced for sex and experience, each of whom counseled one male and one female from both preference categories (i.e., prefer male, no preference). Client statements as reported in case notes were analyzed by independent judges using the Kelly and Fiske Relationship

Index. Female clients expressed significantly more feeling in intake interviews, with no effect of client preference. In first interviews, clients with no preference expressed significantly more feeling than clients who preferred male counselors, but there was no client preference-counselor sex interaction. Significantly more feeling was expressed in pairs containing a female either as client or counselor than in all-male pairs. No-preference clients' feeling scores increased significantly more from intake to counseling than did scores of those who preferred male counselors, as did female no-preference clients compared with male no-preference clients and male clients who preferred male counselors. There was significantly more increase in feeling expressed in pairs containing a female, regardless of whether the female was the client or the therapist. When assignments contrary to client preference were eliminated, there was increased expression of feeling with counselor experience alone. However, when contrary preference assignments were made, both counselor experience and assignment congruent with client preference resulted in greater expression of feeling. The authors identify two possible limitations: (1) the reliability of counselors' notes and possible sex-related difference in their expression and interpretation of emotional statements; and (2) the lack of clients who preferred female counselors. They also note the possible limitation of the fact that findings are based on educational-vocational rather than emotional problems.

112.

Gabbert, Karen H.; Ivey, Allen E.; and Miller, C. Dean. Counselor assignment and client attitude. *Journal of Counseling Psychology*, 14(2):131-136, 1967.

The authors hypothesized that attitudes of clients seen by different counselors would vary according to their sex, diagnostic category, and duration of counseling. Subjects were student clients (267 male, 138 female) at the Colorado State University Counseling Center assigned to three staff counselors or to one of five graduate student counselors (results for graduate student counselors were combined). All counselors except one graduate student were male. One hundred sixteen subjects were seen once; 184 subjects, twice; 62 subjects, three times; and 43 subjects, four or more times. Clients were treated as two separate groups in the analysis and were differentiated according to whether the major presenting problem was educational/vocational (EV, $N = 232$) or personal/psychological (PP, $N = 173$). In the PP group, clients with different counselors had significantly different attitudes toward their counselors ($p = .01$). The more counseling sessions an individual had, the more favorably was the counselor viewed ($p = .01$). The most positive attitudes were held by male clients seen for three or more interviews and for those seen for three or more interviews by Counselor 2. Less favorable attitudes were held by male clients seen for one interview and clients seen for one interview by Counselor 3. All of these effects were significant at the .01 level. For the EV group of clients, neither the main effects of sex, counselor, or number of interviews nor their interactions were found to be significantly related to the client's attitude toward the counselor. When EV and PP clients were combined, and analysis of variance of the attitude scores by counselor revealed a significant difference between counselors. The variables related to favorable client attitude were identified in separate analyses of the responses of each counselor's clients. A number of effects were significant at at least the .05 level. Counselor 1 received best attitude scores from male, EV clients seen for three or more interviews. Counselor 2 appeared to be most liked by female, PP clients who continued to use counseling for three or more interviews. No significant effects were shown to be related to positive attitudes toward Counselor 3. The five graduate students were most positively rated by female, EV clients who had three or more sessions. The authors conclude that counselor assignment and characteristics influence client attitude toward the counseling experience, and, depending on the counselor involved, the variables of sex, duration of counseling, and problems discussed seem to be differentially related to the attitude of clients toward the counseling they received.

113.

Gamsky, Neal Richard, and Farwell, Gail F. Counselor verbal behavior as a function of client hostility. *Journal of Counseling Psychology*, 13(2):184-190, 1966.

Gamsky and Farwell investigated effects of focus of client's hostility (counselor-directed or other-directed) on verbal responses of school counselors. Counselor experience and sex of client and counselor were other independent variables in a paradigm using client actors and 30 school counselors. Counselors ranged in age from 22 to 57, and could be characterized as inexperienced (students with a maximum of three relevant courses and no supervised fieldwork), moderately experienced (all courses for the masters' degree and one semester of fieldwork), and experienced (masters' degree, one semester of field experience, and 1 year of school counseling). There were five male and five female counselors in each experience level group. All counselors saw "clients" in half-hour interviews that they believed were real. Clients played four roles—friendly male, friendly female, hostile male, and hostile female. They initially presented educational-vocational problems but then interjected problems of parental pressure. Hostile clients switched their hostility focus from parents to the counselor midway through the interview. Tape recordings of interviews were then rated on a revision of the Bales Interaction Process Analysis Categories by three female graduate students. The authors report that experienced counselors avoided hostility less than both other groups and used agreement more than moderately experienced counselors. Client focus of hostility significantly affected 11 of 14 verbal response categories: counselors used significantly more reassurance, suggestion, information giving, avoidance, disapproval, and antagonism when the focus of hostility was shifted to them. Counselor sex had no significant effect in any of the response categories but did have a significant effect on counselor use of six verbal responses. Counselors used more tension release, agreement, reflection, and requests for information and elaboration and less disagreement with male hostile clients than with female hostile clients. The authors suggest, however, that these results may have been due to extraneous uncontrolled client variations and by failure to randomize timing of change in focus of hostility.

114.

Geer, Carol A., and Hurst, James C. Counselor-subject sex variables in systematic desensitization. *Journal of Counseling Psychology*, 23(4):296-301, 1976.

The authors write that few studies have dealt with the effects of client and therapist sex on systematic desensitization. They examine the effect of the sex variables on the treatment of test anxiety by systematic desensitization at the Colorado State University Counseling Center. the Suinn Test Anxiety Behavior Scale (STABS) was used to test 915 students. The most anxious students were invited into treatment. Thirty females and 24 males volunteered to participate. The volunteers were divided by sex and randomly assigned to a male or female counselor. Six students were referred to alternative services, because an initial screening interview indicated that desensitization was an inappropriate treatment, and four students were eliminated from the study because of scheduling problems. The treatment included pretesting, ½-hour of relaxation training, a 2-hour session, and three 3-hour sessions. A control group received the pretesting and posttesting followed by desensitization treatment. The posttest contained two measures of test anxiety, the STABS and the Symptom Checklist. Analysis of variance was used to test the effects of client sex, counselor sex, and the interactions between these effects. Anxiety was significantly reduced in both the male and female counselor treatment conditions when compared to the control group conditions. There was a significant difference on the pre- and posttreatment performance of females under male counselor condition; females in the female counselor group tended to report less reduction of anxiety than females in the male counselor group. All of these results were significant at th[illegible]vel. Additional findings pertaining to males in treatment an[illegible]eatment effects are presented.

115.

Heilbrun, Alfred B. Effects of briefing upon client satisfaction with the initial counseling contact. *Journal of Consulting and Clinical Psychology*, **38(1):50-56, 1972.**

Heilbrun investigated the degree to which client satisfaction with an initial professional contact was affected by a briefing session. In the briefing, which took place before the first counseling session, relevant information was provided to the client concerning therapist directive-nondirective behavior. Clients were 44 male and 41 female students at Emory University, most with educational-vocational ($N = 32$) or personal problems ($N = 51$). Clients were rated on the Counseling Readiness Scale of Gough's Adjective Checklist as being of high ($N = 42$) or low ($N = 43$) readiness for counseling. Counselors (one female and four male senior staff members) were rated by clients on a scale of satisfaction with the directiveness of the interview; counselors also rated their own directiveness. Briefing booklets describing directive and nondirective approaches were given to half of the subjects. Heilbrun reports that there was a significant Counseling Readiness × Briefing interaction for female clients, and a trend for briefing to result in less satisfaction for male clients of both high- and low-counseling readiness. Among nonbriefed subjects, rated directiveness of counselor was significantly greater for male than for female clients. Briefing had no effect on continuation for high-readiness clients but did positively affect low-readiness subjects' continuation. Thus, client satisfaction with directiveness in initial interviews was significantly enhanced by briefing only for female high-readiness clients. Heilbrun indicates that for this type of client, briefing may facilitate behavior directed toward eliciting the preferred level of counselor directiveness, whereas subjects unready for counseling might find such information frustrating as they would be unable to make appropriate use of it.

116.

Heilbrun, Alfred B. Male and female personality correlates of early termination in counseling. ***Journal of Counseling Psychology,*** **8(1):31-36, 1961.**

Heilbrun investigated the personality differences between male and female counseling subjects who terminate counseling relatively early in the process and those who continue. Various studies have compared early and late terminators on demographic, intellectual, and personality dimensions, but the possible importance of the client's sex has not previously been evaluated. The subjects were 73 college students (3 were students' wives) who were in treatment at the State University of Iowa Counseling Center. Demographic and intellectual variables were fairly consistent for the four sex/duration groups: female nonstay ($N = 19$), female stay ($N = 19$), male nonstay ($N = 21$), and male stay ($N = 14$). A subject with six or more interviews was assigned to the stay group; the defining characteristic for all nonstay subjects was early termination of contact with the Center. Each subject was tested before the initial counseling contact. The personality measures used were eight Need Scales developed from the Gough Adjective Checklist—three process-oriented (achievement, intraception, and endurance) and five relationship-oriented variables (deference, autonomy, succorance, dominance, and abasement). Possible interaction effects among need, sex, and stay were evaluated by *t* tests. The author reports a significant interaction among need, sex, and duration on five variables—achievement, deference, autonomy, dominance, and abasement. Stay-nonstay characteristics were opposite for males and females. Female nonstays tended toward lower achievement needs, more deference, less autonomy, less dominance, and more abasement than female stays; male nonstays had the opposite characteristics compared to male stays. Heilbrun suggests that those subjects with needs closer to cultural stereotypes tend to terminate counseling earlier whereas those with characteristics considered typical of the opposite sex tend to continue in treatment. These results were supported by analysis of the California

Psychological Inventory Femininity scale for 65 subjects. Heilbrun indicates that results were not clear cut, because all counselors were men and the Center uses an approach stressing client responsibility. He suggests, therefore, that duration may have resulted from the unwillingness or inability of the more feminine, dependent female to accept the responsibility of self-analysis and the more masculine, independent male to accept the reduced status of client vis-à-vis another man.

117.

Hill, Clara E. Sex of client and sex and experience level of counselor. *Journal of Counseling Psychology*, 22(1):6-11, 1975.

In a study investigating same-sex and opposite-sex pairings of counselors and clients, the interactive effects of the counselor's sex and experience on behaviors used in the counseling session were studied. Subjects were 12 male and 12 female counselors whose second meetings with 24 male and 24 female clients who had voluntarily sought counseling were tape recorded. Frequency counts were made of 11 discrete verbal behaviors of the counselors, and client verbal behavior was similarly classified. A 7-point scale (perfect to very poor) of satisfaction was completed by both the client and the counselor after the session. Five-point scales were used to measure empathy and depth of self-exploration; a male and a female judge unfamiliar with the purpose of the study applied these scales. Indicators were also obtained by an advanced graduate student in psychology of the percentage of time the client and the therapist talked, number of topic changes, and the person responsible for topic changes. Multiple linear regression analysis was used to examine the effects of client and counselor sex and counselor experience on 18 process and outcome measures. Same-sex pairing of the counselor and the client was associated with more counselor verbal behaviors that were coded as reflecting feeling and meaning ($p = .019$). Same-sex pairing was related to fewer genuine responses, especially for female counselors with female clients ($p = .007$). Experience was positively related to a high frequency of positive confrontation ($p = .04$). For inexperienced counselors, the most disclosure was made by counselors with their male clients, and the least was made by female counselors with their female clients; for experienced counselors, the most disclosure was with the opposite-sex pairings, especially for female counselors with male clients ($p = .009$). With inexperienced counselors, same-sex pairing resulted in more advice; female clients were given more advice by all counselors, including experienced ones ($p = .013$). Inexperienced female counselors questioned all clients a moderate amount, but male counselors questioned male clients least and female clients most ($p = .010$). Sex referent frequencies were lowest for the same-sex pairings, and highest for opposite-sex pairings ($p = .011$). Affective self-referents were higher for same-sex than opposite-sex pairs, especially when the counselor was an inexperienced male or an experienced female ($p = .027$). All clients were most satisfied with female counselors ($p = .039$). The most satisfied counselors were inexperienced males and experienced females, whereas the least satisfied were inexperienced females and experienced males ($p = .016$). Inexperienced males were judged more empathic than inexperienced females; of the experienced counselors, females were judged more empathic with female clients but less empathic with males, whereas males were at an intermediate level with all clients ($p = .048$). Inexperienced males were judged more empathic than inexperienced females, and of the experienced counselors females were judged as more empathic with female than with male clients, whereas male counselors were at an intermediate level with all clients ($p = .021$). At an inexperienced level, males did more talking, whereas at an experienced level, opposite-sex pairings led to more counselor talking ($p = .003$). For inexperienced counselors, same-sex pairings resulted in more counselor initiation of topics, especially for males; at an experienced level, counselors initiated more topics with male clients, particularly if the counselor was a female ($p = .020$). Other results related to male clients and to counselor's experience are reported. The counseling experience was influenced by the sex of the client and by the sex and experience level of the counselor. Hill suggests that counselors should be made aware that they do behave differently with different clients and that this does affect the counseling process. By heightening awareness of such differences, the training of counselors might be improved.

118.

Hill, Clara E.; Tanney, Mary Faith; Leonard, Mary Margaret; and Reiss, Jo Ann. Counselor reactions to female clients: Type of problem, age of client, and sex of counselor. ***Journal of Counseling Psychology*****, 24(1):60-65, 1977.**

The authors investigated the effect of various types of problems on therapist reaction to a group of female clients. Reactions of therapists to four types of problems were compared: a traditional vocational problem (social work), a nontraditional vocational problem (engineering), a sexual personal problem (feared rape), and a nonsexual personal problem (existential anxiety). Differences in response according to client age and counselor sex were also examined. The following dependent measures were used to evaluate counselor response to videotaped vignettes of female clients: empathy ratings, counselor estimates of the severity of the problem, counselor ratings of the client's ability to profit from counseling, attractiveness of the client, and number of sessions needed. The 88 subjects (44 female and 44 male) were graduate students in counseling-related fields, staff members of a university counseling center, and faculty in counseling education, counseling, and clinical psychology. They were randomly assigned to view videotapes that varied in the type of problem of the client and the age (20 or 35) of the client. A repeated-measures analysis of variance on each dependent variable for the four problem groups resulted in a statistically significant test in every case. Duncan's multiple range test was used to determine whether means differed from each other significantly. Factorial designs were used to assess the effect of counselor sex and client age on each independent variable for each of the four groups of clients. For the group that feared rape, the following findings were statistically significant: female counselors viewed treatment as more profitable than did male counselors, female counselors were more empathic than male counselors, and younger clients received more empathy than older clients. The statistically significant finding for the group whose problem was existential anxiety was that female counselors rated the younger woman's problems as more serious than the older woman's problems. For the group with a traditional vocational problem (social work), the statistically significant finding was that the female counselors were found to rate the older woman's problem as more serious than the younger woman's problem. Finally, for the women with a nontraditional vocational problem (engineering), female counselors viewed treatment as more profitable than did males and the 35-year-old client was given more empathy than the 20 year old. The authors conclude that their study supports previous findings of greater counselor responsivity to personal-emotional than vocational difficulties of clients. They suggest that research should not consider women as a homogeneous group but should examine differences in therapist response that are based on type of problem and age of client, as well as sex of the client.

119.

Kirshner, Lewis A.; Hauser, Stuart T.; and Genack, Abraham. Effects of gender on psychotherapy. *Psychotherapy: Theory, Research and Practice*, in press.

The authors provide a comprehensive review of studies of the effects of gender on psychotherapy. They then report on their own systematic analysis of the effect of therapist gender upon male and female patients' satisfaction and feelings of improvement. A sample of 395 patients (53 percent male, 47 percent female) was drawn from an outpatient university health service available to undergraduates, graduate students, faculty, and employees. Patients were seen for three or more outpatient psychiatric visits between September 1972 and August 1973 and were mailed a questionnaire in May 1974. Of the 189 respondents, 49 percent were male, 51 percent were female; the average social class was upper-middle; and the majority were under 30 years of age. The 22 psychotherapists (17 male and 5 female) were classified as either junior or senior based upon their experience, with senior therapists having between 10 and 25 years of post-training experience. Most of the therapists were less experienced males. One therapist was a psychologist, one a social worker, and the remaining 20 were psychiatrists. The questionnaire included factual items, 7-point improvement scales covering a range of possible areas for change, and a 9-point satisfaction with treatment scale. Therapists received the same satisfaction with treatment scale and a single improvement scale which referred to the "main problem area." Univariate t tests were used to analyze differences in male and female patients' improvement and satisfaction scores. Females had higher self-rated improvement in attitude toward career ($p < .002$), academic motivation ($p < .067$), academic performance ($p < .107$), and family relations ($p < .108$). Patients of both sexes reported greater improvements in self-acceptance ($p < .029$) when they were seen by a female than by a male therapist. A three-way ANOVA (sex of therapist, experience of therapist, university status of patient) revealed that the patients of female therapists reported significantly more improvement in self-acceptance than those of male therapists ($p < .029$) as well as more satisfaction ($p < .055$). Also, patients of female therapists rated themselves as more satisfied and improved than their therapists did, which was not true for patients of male therapists. There was more congruence between the patient's and the therapist's ratings of satisfaction and improvement when the therapist was a female. Some significant interactions between sex of patient and sex of therapist were found when the experience of the therapist was taken into account. An analysis of 347 codable responses of therapists provided evidence that junior therapists were more satisfied with female patients. If the patient was an undergraduate, male therapists were more satisfied with female patients. In the group of therapists whose responses could be coupled with patient responses, female therapists reported more satisfaction when treating female than male patients. This difference did not exist for male therapists and was not influenced by therapist's experience. In their conclusion the authors stress the importance of separating gender effects from other effects (e.g., experience), and they note that when variable interactions were considered, women did appear to be consistently more responsive to and effective in psychotherapy than men.

120.

Mendelsohn, Gerald A., and Geller, Marvin H. Structure of client attitudes toward counseling and their relation to client-counselor similarity. ***Journal of Consulting Psychology*****, 29(1):63-72, 1965.**

In two studies, the authors investigated relationships among clients' questionnaire ratings of the counseling experience, similarity of client and therapist on the Myers-Briggs Type Indicator (MBTI; a self-report personality inventory based on Jungian concepts), and sex of client and therapist. Subjects in the first study were 41 female and 31 male undergraduates who had previously taken the MBTI and were sent a postcounseling questionnaire (62 percent return rate); counselors' MBTI data were collected later. Subjects in the second study were 178 undergraduate and graduate students who took the MBTI before the first counseling interview and were sent a questionnaire 3 months after the last interview (72 percent return, 67 males and 62 females). Counselors in the first study were 6 females and 4 males and, in the second study, 6 females and 5 males (a total of 15 different counselors). Questionnaires in the first study consisted of 21 items rated on a 1-5 agree-disagree scale; a refined 27-item version with a 7-point scale was used in the second study. Three clusters of items were identified—comfort-rapport, evaluation of counseling experience, and judged competence of therapist. The authors indicate that the series of low positive correlations among the clusters suggests that responses were not dictated by a set determined by a particular aspect of the experience. Evaluation had a curvilinear relationship to client-counselor similarity as rated on the MBTI, with middle similarity producing the highest satisfaction. Judged competence of therapist was nonsignificantly associated with low similarity, with no significant effect of client-counselor sex pairing. Comfort-rapport scores were related to high similarity for freshmen but to middle similarity for other students. On both comfort-rapport and evaluation clusters, low similarity was related to more favorable ratings by nonfreshmen but less favorable ratings by freshmen. All of these effects tended to be more pronounced in opposite-sex than same-sex pairings, particularly for nonfreshmen. To explain the marked interaction between similarity and sex matching for nonfreshmen, the authors suggest that being paired with an opposite-sex counselor of similar personality may be confusing and uncomfortable for students who are trying to solidify identifications.

121.

Orlinsky, David E., and Howard, Kenneth I. The effects of sex of therapist on the therapeutic experiences of women. *Psychotherapy: Theory, Research and Practice*, 13(1):82-88, 1976.

Focus in this study was on the effect of therapist's sex on the treatment process. To address this question, data that had been collected from 118 women outpatients in therapy for another study were reanalyzed. Seventy-eight of the patients had a male therapist, and 40 had a female therapist. The data consisted of patients' multifaceted descriptions, on the authors' Therapy Session Report questionnaire, of their experiences in 2,318 therapy sessions. The patients ranged in age from 18 to 61; 47 percent had been married, 35 percent had children, and 78 percent were employed. They were considered typical of others who have been surveyed in major metropolitan mental health centers. Factor analysis was used to identify a clinically meaningful set of 46 dimensions of patient and therapist behavior and feelings. *T* tests were used to determine the significance of differences between male and female clients on each of these dimensions. Fifteen of the 46 dimensions of patient experience showed some statistically significant difference simply as a function of the sex of the therapist. Women with male therapists talked more about the opposite sex and about their involvement with the therapist. They expressed a greater desire to obtain insight through therapy and were more concerned about identity-related issues; they felt more erotized [sic] affection, anger, inhibition, and depression than their counterparts and saw their therapists as more demanding, more detached, and less expansive. Patients with male therapists also experienced themselves in treatment as being less self-possessed, less open, more self-critical, and as getting less encouragement. Women in therapy with female therapists, as a group, reported significantly higher levels of satisfaction in regard to encouragement but were not significantly different in levels of catharsis, mastery, and insight or overall experienced benefit. Additionally, patients were differentiated according to their life statuses: younger single women, single women, independent women, young married mothers, young divorced mothers, and family women. Women in the various life status categories differed as follows. Younger single women (i.e., 18-22 years old) and single women (i.e., 23-28 years old) were clearly the most reactive to the sex of the therapist; all other groups were very substantially less reactive, and independent women were essentially immune. Younger single women with male therapists reported more intense desires for active input from the therapist; greater concern with their identity, fear and anger; felt more inhibited, less self-possessed, and less open; and viewed the therapist as feeling more detached and demanding in comparison to other women with female therapists. However, they did not experience therapy as less productive than their counterparts with female therapists. Single women with female therapists did report significantly higher levels of experienced benefit and found more encouragement and mastery-insight with female therapists. They also felt more open and self-possessed in therapy; less self-critical; less inhibited, depressed, and angry; more confident and less needful of catharsis; and they perceived their therapist as more expansive and accepting. In interpreting these findings, the authors suggest (1) that the patients, and not the therapist, account for different experiences in therapy as men have an enormous emotional significance to young, unattached women or (2) that male and female therapists react differently to patients who vary in their life situations. The authors also examined data from the perspective of diagnostic categories. They conclude that although the sex of the therapist made little difference for many patients, their analyses strongly suggest that patients who are single women and who are diagnosed as depressive reactions will feel more support and satisfaction in treatment with a woman therapist.

122.

Parker, George V.C. Some concomitants of therapist dominance in the psychotherapy interview. ***Journal of Consulting Psychology*, 31(3):313-318, 1967.**

Noting that differences in verbal behavior of therapists may be significant in management and prognosis of therapy, Parker reports on his investigation of directive and nondirective verbalizations of 16 therapists as a function of dominance. The therapists, male counselors-in-training at university counseling centers, were divided into high- and low-dominance groups (eight in each group) on the basis of scores from the Gough Adjective Checklist. One male and one female client were randomly selected from each therapist's caseload, and initial sessions were taped and transcribed. Transcripts were analyzed by 32 graduate students according to a schema that classified each therapist statement into 1 of 20 categories divided into directive and nondirective groups. Therapists gave more nondirective than directive responses to all clients, but the rate at which the two types of responses occurred was a function of dominance—high dominance therapists gave a significantly higher proportion of directive than nondirective responses. Verbal behavior was significantly influenced by sex of interviewee—therapists gave significantly more nondirective responses to female than male clients; low-dominance therapists gave relatively few directive responses to female as compared to male clients. In discussing the implications of these results, Parker suggests that since some highly directive responses may have a deleterious effect on therapy, there may be an inverse relationship between therapist dominance and success of therapy. He adds that the data also indicate that inexperienced male therapists tend to give female clients more responsibility than males for the course of the initial interview.

123.

Persons, Roy W.; Persons, Marilyn K.; and Newmark, Irene. Perceived helpful therapists' characteristics, client improvements, and sex of therapist and client. ***Psychotherapy: Theory, Research and Practice*, 11(1):63-65, 1974.**

As a part of a larger study of the difference between professional and paraprofessional therapists, the researchers examined the effect of the sex of the therapist and client on the client's perception of helpful therapist characteristics and client improvements. The sample consisted of 93 Antioch College students who had improved after receiving therapy from trained undergraduate therapists. At the end of the therapy, a secretary asked each client to list helpful and nonhelpful characteristics of the therapist and changes that the client had made as a result of therapy. Two independent judges made frequency distributions of client statements. When the therapist was female, female clients listed more than three times as many helpful characteristics than did male clients. Regardless of whether the therapist was male or female, male clients were more responsive to honest feedback than female clients. Female clients were more responsive to therapists' encouragement of risk taking, perceptivity and insightfulness, empathy, and supportiveness. All of these results were significant at the .05 level. When the responses of female clients to male and female therapists were compared, these clients were found to view female therapists as more perceptive and insightful, encouraging more risk taking, more warm and friendly, more helpful with sexual identity concerns, more honest in giving feedback, more self-disclosing, and more supportive. A similar comparison of male clients' reactions to male or female therapists was carried out. Only when the therapist had an opposite-sexed client were no helpful traits listed. Asked about gains in therapy, female clients gave four times as many responses as males ($p < .01$), and women gave more than two times the number of responses when they had a female therapist than when they had a male therapist ($p < .05$). The authors briefly discuss the implications of their findings and the degree to which they can be generalized to other groups of therapists and clients.

124.

Safer, Jeanne. Effects of sex of patient and therapist on length of therapy. *International Mental Health Research Newsletter*, 17(2): 12-13, 1975.

In a brief report, Safer discusses the effects of sex of patient and therapist on length of therapy. Her study is a continuation of an earlier study (Riess and Safer, 1973) which showed that female/female dyads tended to have the longest lasting therapeutic relationships. The sample source is the files on outpatient psychotherapy clients at the Postgraduate Center for Mental Health who had terminated therapy over the past 5 years. Twenty-five subjects who had been seen either on a once- or twice-weekly basis were selected in each of four possible combinations of sex of patient and therapist. Mainland's short form of chi square was used to compare these eight groups statistically in order to test for differences in length of treatment. Therapist's sex made no difference in the length of treatment of female patients who were seen either once or twice weekly. When patient and therapist were of opposite sexes, male therapists kept female patients in treatment significantly longer than female therapists kept male patients. When patient and therapist were of the same sex, there was no significant difference in length of treatment for once-a-week therapy, but male/male pairs worked together significantly longer when therapy was conducted on a twice-weekly basis. Concluding that these findings are essentially unexplained, Safer suggests the need to examine whether there has been a "male consciousness-raising backlash" which could be responsible for the longer duration of male/male therapeutic relationships. She adds that future study efforts will focus on specifying characteristic differences such as style, affect, and dynamics in the various sexual combinations of patient and therapist in order to determine how particular patients could benefit from the difference.

125.

Scher, Murray. Verbal activity, sex, counselor experience, and success in counseling. *Journal of Counseling Psychology*, 22(2):97-101, 1975.

This study focuses on the verbal activity of therapist and client. Scher hypothesized that better therapy outcome would be associated with high verbal activity and more experienced counselors but not with client or therapist sex. Eighteen male and five female counselors at the Counseling-Psychological Services Center at the University of Texas at Austin voluntarily participated in the study. Nine of the counselors were experienced and 14 were inexperienced; experience was defined as holding a Ph.D. in counseling or clinical psychology or having 2 years of counseling experience. Twenty female and 16 male student clients also voluntarily participated. The first, second, fifth, and final counseling sessions of the subjects were audiotape-recorded. Counselor effectiveness was determined by rating the tapes for nonpossessive warmth and genuineness, and counselors with low ratings were excluded from the study. Then, for the remaining study subjects, verbal activity of the counselors was rated as high, medium or low. A multiple regression analysis demonstrated that only experience of the counselor was significantly related to therapy outcome as measured by Forms A and B of the Counseling Services Assessment Blank and Forms A and B of the Counselor's Assessment Blank. Scher points out that other dimensions of verbal activity besides quantity may be predictive of therapy outcome. The Counselor Experience × Client Sex interaction was significant for one item measuring client-reported symptom relief and one item measuring client-reported satisfaction, which indicated that dyads involving experienced counselors with male clients and inexperienced counselors with female clients reported greater therapeutic success. Scher concludes that counselor sex and client sex and the interaction thereof are not significant predictors of the outcomes of counseling. He adds that this does not mean that clients might not benefit more by seeing a same-sexed or opposite-sexed therapist for particular problems but rather suggests that gender in and of itself is not a significant predictor. In discussing implications of the findings, Scher writes that successful therapeutic outcomes of symptom relief and satisfaction are partially predictable by counselor experience, but counselor and client sex and counselor and client verbal activity are not predictors of therapeutic success.

Effect of Sex of Client on Process and Outcome of Various Treatment Approaches

126.

Bateman, Nils I., and Peterson, David M. Factors related to outcome of treatment for hospitalized white male and female alcoholics. ***Journal of Drug Issues*, 2(1):66-74, 1972.**

This study was designed to determine what factors can aid in predicting treatment outcome for hospitalized alcoholics. Factors that had been dealt with in earlier studies were combined with factors that had not previously been related to outcome, including comparative information for male and female patients. The sample was drawn from 719 patients who had voluntarily completed a 28-day treatment program at a State rehabilitation center in the South from February 1962 to June 1963. The 719 patients were mailed a followup questionnaire 6 months after their discharge. Efforts were made to obtain data from relatives, friends, and outpatient clinics for those patients who did not respond. The final sample was 72 percent of the total—381 men and 136 women. The authors describe admission procedures and the types of alcoholism encountered in the patient population. The psychiatric team approach is the basis of the program, with medical care, environmental stability, group therapy, and posthospital planning included in the treatment process. The followup questionnaire included the question, "Have you had a drink during the last 6 months?" Outcome was measured by the reply—either "drinking" or "abstinent." Of the total sample 28.2 percent indicated that they were "abstinent" and 71.8 percent reported "drinking." One-hundred sixteen (30.4 percent) of the males responded that they were abstinent compared to 30 (22.1 percent) of the females; this difference was significant at a relatively low level (chi square = 3.47, 1 df, $p < .10$). Of all the factors dealt with in the questionnaire related to outcome, only two were found to be statistically significant for both the male and female patients—being over 45 years of age and being employed proved to be related to higher abstinence rates for both sexes. Treatment outcome for women was found to be related to many factors that had no importance for men. Three aspects of social status were significantly associated with good outcome for women—low social status, low educational achievement, and low occupational status. Higher intelligence was significantly related to a better prognosis in women, and this finding is compatible with the findings of previous studies. However, women who began to drink before age 20 also had a higher incidence of abstinence (chi square = 5.85, 1 df, $p < .02$), and these data are in conflict with an earlier study that dealt primarily with men. The factors relating to favorable prognosis for men patients were a period of abstinence of at least 1 week before entering treatment, prior regular attendance at Alcoholics Anonymous meetings, and the fact that their mothers were dead. The most important conclusion of the study is that different factors have importance for outcome of treatment in men and women and that data for the two groups must be analyzed separately. A table summarizing the factors related to treatment outcome for males and females is provided.

127.

Cooperstock, Ruth. Sex differences in the use of mood-modifying drugs: An explanatory model. *Journal of Health and Social Behavior,* 12(3):238-244, 1971.

This article is based on an exploratory study initiated in 1965 by the Addiction Research Foundation in Toronto, Canada, to determine the extent to which various mood-modifying drugs were prescribed for different categories of a noninstitutionalized urban population. Prescriptions were recorded from a stratified sample of 72 retail pharmacies and all the city hospital outpatient pharmacies. The number of mood-modifying prescriptions filled yearly per 100 adults in Canada was compared with the number in the United States, and the distribution of classes of drugs included in this study was compared with a sample of prescriptions from the United States. The most striking findings were related to sex. Of all the prescriptions for mood-altering drugs, 69 percent were for women. Cooperstock notes that this high percentage of women recipients is also evident in the studies of the United States. Escape drinking on the part of men and the greater number of women seeing physicians can provide only partial explanations for this finding. The author presents a model based on the findings of this and other studies to explain why a disproportionate number of women are prescribed mood-modifying drugs. According to the model, women in this culture have greater freedom to express their feelings and are also much more likely than men to perceive their own emotional problems. Additionally, women are more likely to bring emotional problems to a physician's attention because of cultural expectations. Physicians, as members of the culture, expect women to be more emotionally expressive and more in need of mood-modifying drugs than men. Several studies are cited in support of this model. The author concludes that the use of mood-modifying drugs can only be understood within its social context. The model presented is identified as a form of suggestive theory from which more refined hypotheses can emerge.

128.

Curlee, Joan. A comparison of male and female patients at an alcoholism treatment center. *Journal of Psychology*, 74(2):239-247, 1970.

Curlee notes that a number of differences between male and female alcoholics have been reported in the literature, but little attention has been paid to whether such findings can be generalized to other populations. The sample considered in this study was drawn from the population of patients at Hazelden, an alcoholism treatment center in Center City, Minn. One-hundred consecutive admissions to a male living unit and 100 consecutive admissions to a female living unit were compared on the basis of a social history and results of the Minnesota Multiphasic Personality Inventory, the Shipley-Institute of Living Scale, a Sentence Completion test, and a questionnaire completed at the time of discharge. The men ranged from age 19 to 68 (mean, 47.72) and the women from age 17 to 71 (mean, 46.75); most of the patients were in the middle or upper middle class. Seventeen of the men and 14 of the women had less than a high school education. Sixty-two of the men and 63 of the women had obtained some education beyond high school. The results of the various personality assessment tests showed similar mean profiles for males and females but differed on some individual scales. On the Minnesota Multiphasic Personality Inventory, more women than men had a T score above 70 on Scales 3 (Hysteria) and 4 (Psychopathic Deviate). More men than women had a T score above 70 on Scale 9 (Mania). Women had low T scores on Scale 5 (Masculinity-Femininity). The groups were similar in their numbers of "normal profiles" and "psychotic profiles." Another difference reported by the author is that men expressed their anxiety more openly than women. Despite the relatively few differences between the personalities of men and women, there were many differences in the patterns of hospitalization and illness in the two groups. Social histories reflected that more women had been admitted as psychiatric patients, had been admitted for a longer period of time, and had made extensive use of outpatient treatment. Also, more women than men complained of depression at the time of hospitalization, had attempted suicide, and had received convulsive therapy. Women had experienced more divorce and separation than men, which is seen as an indicator of their social instability. For women, alcoholism was more frequently related to a particular life situation, usually a disruption in the role of wife and mother, than it was for men. Curlee regards her findings pertaining to differences in the speed of onset of alcoholism and differences in the amount of alcoholism in family members reported by men and women as inconclusive. Relatives tended to ignore the alcoholism of women in comparison to alcoholism of men. Women were more likely than men to have taken mild tranquilizers and sedatives and to have problems with the use of these medications. The author offers three alternative explanations for her findings: (1) women exhibit more symptoms of their disturbance than men; (2) society more readily recognizes women than men as mentally ill; and (3) there is some interaction between these factors.

129.

Curlee, Joan. Sex differences in patient attitudes toward alcoholism treatment. *Quarterly Journal of Studies in Alcohol*, 32(3):643-650, 1971.

Results of a survey conducted at a private alcoholism rehabilitation facility to determine possible sex differences in patient attitudes toward aspects of treatment are reported. One-hundred consecutive male and 100 consecutive female admissions were chosen to participate in the study. All participants represented primarily the upper and middle class, and their ages ranged from 17 to 71. No formal psychiatric diagnoses were made, but the two groups revealed similar patterns on the Minnesota Multiphasic Personality Inventory. Upon leaving the facility, after an average stay of 3 weeks, each subject was asked to complete a questionnaire rating 10 aspects (2 were optional) of the treatment program in order of their helpfulness. Both the male and female groups agreed on the three highest ratings—lectures, contact with counselor, and the fourth and fifth steps (inventory steps of the Alcoholics

Anonymous program in which the person assesses himself or herself and then discusses this inventory with another person). As these aspects form the core of the rehabilitation program, the rankings would only have been important if they had not been high. More important is that the women showed a clear preference in the remaining five activities while the men did not. Women rated the psychological interview they received considerably higher than the men did. This finding supports Curlee's hypothesis that women are more responsive to individual treatment while men prefer group activities. A comparison of the number of men and women giving each activity a top ranking produced several significant results by chi-square analysis. Women gave a statistically significant higher rank to counselor contact and reading while men gave a significantly higher ranking to group therapy and informal contact with other patients. Curlee indicates that many alcoholism treatment programs treat men and women exactly alike. On the basis of this study, she suggests that there are differences in the reactions of men and women to group situations and that all alcoholics should not be categorized and treated similarly.

130.

Doherty, Edmund G. Length of hospitalization on a short-term therapeutic community. *Archives of General Psychiatry*, 33(1):87-92, 1976.

The effects of exhibited and reported behavior and sex on hospital stay were studied in 55 patients sequentially admitted to a hospital ward that was a short-term therapeutic community. The 32 males and 23 females, who were hospitalized for an average of 7 weeks, were all eventually discharged with medical advice. Measures of the following independent variables were obtained: patient biographical and diagnostic characteristics; patient self-ratings; staff ratings of patient functioning; patient perception of ward environment or atmosphere; interpersonal relationships among patients and staff; and patient verbal behavior at randomly selected ward meetings during the first, second, and fourth weeks of hospitalization. For each week during which verbal behavior was measured, the independent variables for each sex were analyzed by a stepwise regression procedure to assess their relationship to the eventual length of hospital stay. For males the items most predictive of a long stay at week 1 were the following: self-rating of being tough or "masculine," relatively low sociometric status or few nominations as being liked by other patients, a relatively lower frequency of nominating other patients as disliked, and having traveled a relatively longer distance to obtain admission to the hospital. At week 2 the predictive items were: receiving a diagnosis that did not fall within a "neurotic" classification, perceiving the ward as encouraging denial and facade regarding the existence or discussion of personal problems, disliking relatively fewer other patients, and rating self as less frequently adhering to conventional and socially accepted standards of behavior. For week 4 the predictive variables were: not receiving a neurotic diagnosis; not receiving a psychotic diagnosis; perceiving the ward as providing structure, order, and organization for patients; receiving relatively few nominations from staff as having helped them; and having been elected to the position of patient chairman by their peers. For female patients at week 1, the variables that were significant predictors of a long hospital stay were: expressing relatively few positive comments about themselves, nominating a relatively large number of patients whom they claimed to have helped, and providing a relatively high self-rating on adhering to conventional and socially accepted standards of behavior. Items predictive of a long hospital stay during the second week were: having relatively few staff members nominate them as being disliked, rating the ward relatively more frequently as not being oriented to personal problems in its approach to patients, and providing relatively frequent self-ratings of feelings of high self-confidence. At the fourth week, variables predictive of longer hospital stay for women were as follows: expressing fewer positive comments about the ward's treatment program, expressing verbally relatively more negative comments about themselves at ward meetings, engaging in relatively more frequent mutually reciprocated helping relationships with other patients, claiming that the ward was not oriented toward patients' personal problems, providing relatively higher self-ratings of being in good physical health, and providing relatively more negative self-reports of being content. The authors point out that both male and female patients whose behaviors could be considered stereotypically "feminine," e.g., accepting rules and conforming to hospital and milieu normative expectations, were released from hospital settings earlier. They note that these findings contradict earlier study results indicating that there is a double standard of mental health applied to males and females.

131.

Edwards, Elizabeth D., and Jackson, Joyce. Rehabilitative services provided women versus men in a substance abuse treatment program.

In: Senay, Edward; Shorty, Vernon; and Alksne, Harold, eds. *Developments in the Field of Drug Abuse: Proceedings 1974 of the National Association for the Prevention of Addiction to Narcotics.* Cambridge, Mass.: Schenkman Publishing Company, Inc., 1975. pp. 505-508.

The hypothesis that male and female clients enrolled in Detroit's substance abuse treatment program do not receive comparable services was tested using vocational counseling, training, and placement as dependent variables. About 30 percent of the program's 225 clients are women and, theoretically, all services are available to both female and male clients—medical care, sociorecreational activities, group and individual counseling, legal consultation, vocational counseling, training, and placement. Subjects were all of the unemployed clients from the program's four centers who were eligible for employment services in January, June, and December 1973—132 females and 162 males. The following data were gathered on each of the subjects: (1) whether they were referred by their counselors to the job placement specialist for vocational services, (2) if referred, the number of services provided to them, and (3) the results of these services. Seventy females (53 percent) were referred to the job placement specialist, and 97 (60 percent) of the men were referred; this difference was statistically significant. Of the remaining 62 females and 65 males who were not referred to the service, 30 percent of the women were not referred only "because they had small children, thus employers would not be interested in hiring them." This response was never given for the males. The most frequent reason for not referring the males (17 percent of the cases) was that they were not drug free. Only 1 percent of the females were in this category. Regarding the frequency of services provided by the specialist to both male and female clients, there was no statistically significant difference between the two groups. A significant difference was found between the two groups, however, in terms of results of services provided. Women were less likely to obtain educational and/or vocational upgrading and placement. Since there was no statistically significant difference in mean educational level for males and females, the counselors appear to make an a priori assumption that women who have small children are either not candidates for employment or, if given an opportunity for employment, would not be able to locate adequate child care to ensure consistent work performance. The authors note that the differences in outcome for the women and men following the provision of vocational services require further study, but they offer several possible explanations. They conclude with suggestions for program intervention to deal with the problem of sex discrimination in treatment.

132.

Esterson, A.; Cooper, D.G.; and Laing, R.D. Results of family-orientated therapy with hospitalized schizophrenics. *British Medical Journal*, 2:1462-1465, 1965.

The authors report on the outcome of conjoint family and milieu therapy with hospitalized schizophrenics. The patients were 20 men and 22 women, ranging in age from 15 to 35, who were consecutively admitted into two London area hospitals according to specified criteria which were the same for both sexes. The principles of the treatment approach are briefly described: (1) systematic clarification and undoing of patterns of communication that were considered to be "schizogenic" within the family and similar clarification and undoing of such patterns of communication between staff and patients; (2) continuity of staff working with the family during and following the patient's hospitalization; and (3) no individual psychotherapy, no use of "so-called shock treatments" and no use of leucotomy. Patients did receive comparatively small doses of tranquilizers. An effort was made to create a human context in which each patient had a relationship with at least one other significant person. To achieve this end, a team of social therapists selected from the nursing staff was trained, and patients also were used in this role. A social therapist was defined as any individual who worked to establish a consistent relationship of trust with the patient. The authors report that all patients were released within a year of admission. Seven (17 percent) were readmitted within another year, and the average length of stay was 3 months. There was no significant difference between men and women in this regard and none between those 33 patients who were discharged home, and the others who went to live in hostels or other lodgings. Of the seven patients readmitted, four were living at home and three away from home; there was no difference between the sexes in this respect. Additionally, 32 patients were discharged to jobs. Twenty-six worked for the entire year following discharge (72 percent of the men and 70 percent of the women); two worked for less than a year but for more than 6 months. Again, there was no significant difference between the sexes. The authors compare their results with those of other studies of the outcome of psychiatric treatment with schizophrenics. They assert that their results are the first to be reported concerning the outcome of purely family and milieu therapy with schizophrenics. They suggest that the results appear to establish at least a prima facie case for the radical revision of the procedures used in most psychiatric units to treat the schizophrenic. Such a revision, they note, is compatible with current developments in social psychiatry in England.

133.

Fitzgerald, Bernard J.; Pasewark, Richard A.; and Clark, Robert. Four year followup of alcoholics treated at a rural state hospital. ***Quarterly Journal of Studies on Alcohol*****, 32(3):636-642, 1971.**

Results of a followup study of 392 males and 139 females who participated in the Alcohol Rehabilitation Program at the Wyoming State Hospital between 1961 and 1965 are presented. The inpatient program required a minimum of 16 weeks of treatment, including an 8-week intensive involvement in an alcohol education program and subsequent involvement in individual counseling and Alcoholics Anonymous meetings. Patients were referred by physicians, community agencies, the courts, and by themselves. The women (aged 18 to 67 years; mean, 42.2) were ranked as having a high occupational level (NORC-Duncan) in 31 percent of the cases, a medium level in 39 percent of the cases, and a low level in 28 percent of the cases. Among the men, (20 to 76 years; mean, 42.8), 16 percent were ranked as having a high occupational level, 41 percent a medium level, and 43 percent a low level. A self-report questionnaire and anecdotal information from relatives, community residents, and cooperating agencies (e.g., Alcoholics Anonymous, the police, the clergy) were used to classify the individuals in one of five sobriety statuses. These ranged from "complete abstinence in the past year and maintaining vocational and familial responsibilities" to "reinstitutionalized primarily for drinking problem in the past year." Two additional categories were "status unknown" and "deceased." The authors report that 44 percent of the sample achieved at least a moderately satisfactory sobriety status by the fourth year as they fell within a category of "drinking with good adjustment" or better. The authors also note that the status of 38 percent of the patients was unknown by the fourth year. Neither sex nor occupational status was significantly related to sobriety status. An analysis of data on the 217 patients whose sobriety was known for all 4 years was conducted, and two thirds of these individuals were maintaining a good adjustment either with or without drinking. One third were described as experiencing a poor adjustment and drinking. Again, there were no differences related to sex. Other findings were that abstinence was sporadic over the 4-year period and that completion of the program was not related to hospital readmission. During their first hospital admission, women were more likely than men to leave the program before completion. This was not predictive, however, of whether they would complete the program if readmitted. The authors emphasize that their findings regarding the differential dropout rates of males and females is of particular interest to treatment programmers. Suggested explanations are that females experience more difficulty in adjusting to an absence from home or more pressure to return home, or that the treatment program somehow fails to recognize the special needs of females. More research that could explain the differential dropout rate is recommended.

134.

Glatt, M.M. Treatment results in an English mental hospital alcoholic unit. *Acta Psychiatrica Scandinavica* (Kobenhavn), 37(2):143-168, 1961.

Glatt reports that sex and premorbid personality (psychopathic versus nonpsychopathic) were the factors most significantly related to outcome in an English followup study. The sample comprised 71 male and 24 female alcoholics who were followed up 2 to 3½ years after discharge from an English mental hospital alcoholic unit. Reliable information was obtained by personal contact with a majority of the patients. Of the overall sample of 94 patients, one third had no relapse and one third were considerably improved. However, the figures for women were only 42 percent for these combined categories, versus 73 percent for men. Differences between men and women were also found on biochemical assays, with low blood cocarboxylase in 14 percent of men and 32 percent of women. Overall, marital status, age, intelligence, and social class were also found to be significantly related to success, although these differences were much less significant when results were compared for the psychopathic versus nonpsychopathic group, e.g., social status no longer seemed to affect outcome when the personality factor was considered. Since proportions of psychopathic personalities among men and women were similar, other factors are necessary to explain poor outcomes for females. Possibilities include greater premorbid personality problems in women, higher frequency of environmental stresses, loneliness following a marital break-up, menopausal difficulties, and differences in the therapeutic milieu—men lived on a group ward with a highly developed community spirit and a strong support system, whereas women did not. The greater maladjustment hypothesized for women may result from the fact that their drinking behavior represents greater deviance from prevailing social norms than that of men and may therefore have resulted in more stress. First relapses in both groups tended to occur within 6 months, indicating a need for special vigilance during this period. The author recommends that regional alcoholic units be developed to serve therapeutic, research, and educational purposes.

135.

Hoffmann, Helmut, and Noem, Avis A. Sex differences in a State hospital population of alcoholics on admission and treatment variables. *Psychological Reports*, 37(1):145-146, 1975.

The authors investigated whether a population of State hospital alcoholics revealed any sex differences on admission characteristics and treatment variables. Information concerning admission and treatment variables was routinely collected on all rural alcoholics, 2,077 males and 194 females, who were admitted to a State hospital during the years 1971 through 1973. A demographic description of the subjects was provided by the admission variables. Completion of program, length of stay, prognosis, and recommended sources of aftercare were the treatment variables. Only 9 percent of the total admissions to the program were female alcoholics. Since admission policies permitted no selection in the type of patients treated, the authors suggest the following explanation for this finding: (1) there are fewer female alcoholics in rural than in urban areas; or (2) proportionately more female than male alcoholics receive private treatment, because the family is less affected financially if a woman member is an alcoholic. The authors report statistically significant differences between female and male alcoholics on all admission variables. The females were characterized by a greater percentage of first admissions, voluntary referral status, married status, younger age of 25 to 44 years, and a high school education. No statistically significant sex differences were found for the treatment variables of completion of program, length of stay, and prognosis. Rates of referral to 4 of 12 sources of aftercare showed differences significant at the .05 level. Female alcoholics were more frequently referred for aftercare services to community mental health centers and clergy and were less often referred to employer and law enforcement agencies than male alcoholics. The authors suggest that the four aftercare variables that revealed sex differences reflect societal norms and circumstances. Although sex differences were marked in demographic variables as indicated by admission characteristics, males and females seemed to respond similarly to an alcohol treatment program, as revealed by the variables of completion of program, length of stay, and prognosis.

136.

Hogarty, Gerard E.; Goldberg, Solomon C.; Schooler, Nina R.; and the Collaborative Study Group. Drug and sociotherapy in the aftercare of schizophrenic patients: III. Adjustment of nonrelapsed patients. *Archives of General Psychiatry*, 31(5):609-618, 1974.

This study assessed the effects of drug and major role therapy—a combination of intensive social casework and vocational rehabilitation counseling—on community adjustment of schizophrenics. Schizophrenic patients discharged from three State mental hospitals were randomly assigned, stratified by sex, to four groups: drug (chlorpromazine), drug plus major role therapy, placebo only, and placebo plus major role therapy. Adjustment was assessed at 6 ($N = 245$), 12 ($N = 162$), 18 ($N = 129$), and 24 ($N = 112$) months postdischarge on ratings made by patients, relatives, psychiatrists, and the social workers who provided the major role therapy. There were no effects observed on 13 dependent variables related to total pathology ratings at any assessment period, nor was there an extensive main effect of either drug or major role therapy. However, there was an interaction of drug treatment and major role therapy: drug patients who received major role therapy did better than those who did not, whereas placebo patients who were not given major role therapy showed better adjustment. Women who were given active treatments generally did better than those in the placebo condition, and among the total placebo group, men had better adjustment. Sex had an effect on drug-major role therapy interactions: of the patients on drug therapy women were better adjusted than men. Survival (nonrelapse) rates for 2 years were only 20 percent for placebo and 52 percent for drug-treated groups; there were twice as many women as men in the survivor group. Among the survivors, placebo subjects not given major role therapy did better, whereas drug-treated subjects did better with major role therapy. The drug and major role therapy interaction effect did not emerge for 18 months, indicating the need for long-term postdischarge care and evaluation. Sex emerged as an important factor in outcome: women survived longer on active treatment than men—the relatively few male survivors did better without drug or sociotherapy. The authors suggest that the high percentage of relapses in the men may reflect disruptions in the social system that either occur more frequently in men or are more difficult for men to handle. It is also possible that women may respond better than men to the support of a therapeutic relationship because of such factors as insight and motivation.

137.

Keskiner, Ali; Zaleman, Marilyn; and Ruppert, Emily H. Advantages of being female in psychiatric rehabilitation. ***Archives of General Psychiatry*****, 28(5):689-692, 1973.**

It has been suggested that sex-role expectations have led to female patients being treated less effectively than males. To investigate this problem, the effect of sex of chronic psychiatric patients on planning for their rehabilitation was examined. Specifically, the study analyzed the relationships between sex and the patients' referral to a community placement program, acceptance into that program, and actual entry into the program. The program operated in two rural Missouri towns and involved the placement of patients in a "foster community care" setting, i.e., with families or in their own apartments. In the hospital, 302 patients met eligibility criteria for the program. Of the eligible patients, 156 were men and 146 women. Referrals were made for 137 hospital patients, 53 men and 84 women. Seventy-one percent of the women and 47 percent of the men who were referred were accepted into the program. Multiple regression analysis of the relationship of 15 demographic and psychological variables to acceptance into the program revealed that older age at the time of screening, being female, fewer years since the first hospitalization, a shorter duration of the current hospitalization, and a current diagnosis of schizophrenia were each significantly predictive ($p < .05$) of acceptance into the program. A chi-square analysis of sex by each of the variables that had been entered into the regression analysis revealed two significant differences. More women than men had completed high school, partial college, or college ($p < .05$), and more women were in clerical or sales work. Twenty-five people, 4 men and 21 women, were actually placed in the foster community care program. This difference was statistically significant ($p < .03$) according to a chi-square analysis. The sex-related differences in referral to, acceptance in, and actual placement in the foster community program were attributed to the decisionmakers' expectation that men must be able to work in order to live in the community. Most of the women were also unemployed, but a more dependent role was apparently considered acceptable for women. The authors conclude that these findings support the need for basing role expectations on individual preferences and abilities instead of sex. They suggest that systematic studies be conducted concerning the effect of sex-role stereotyping on the delivery of mental health services as well as the patient's and the referring population's perception, acceptance, and utilization of such services.

138.

Levy, Stephen J., and Doyle, Kathleen M. Attitudes toward women in a drug abuse treatment program. *Journal of Drug Issues*, **4(4): 428-434, 1974.**

A study that examined women drug addicts in treatment as a management/clinical rather than as a political issue was conducted at Integrity House, Incorporated, a large drug-free therapeutic community program in Newark, N.J. Subjects included 25 male and 9 female staff members along with 73 male and 23 female residents. Using social control, this program attempts to influence attitudes and behavior 24 hours a day for an extended period of time. The staff completed questionnaires consisting of 25 items along with the 55-item Attitudes Toward Women Scale developed by Spence and Helmreich in 1973. Residents answered a 35-item questionnaire. Analysis of the data revealed the following areas of similarity and differences between males and females on both staff and resident levels: (1) The smaller number of women staff members, their absence at the executive level, and their resulting limited power appear to bias the system toward male clients from the very beginning; (2) female residents are treated differently from males much of the time, and staff members justify this practice as reflecting "societal differences"; (3) generally, the women are regarded as more emotional, more sensitive, more limited by their biology, needing to please men, and implictly "sicker" than the men; (4) staff identifies the women's problems as poor relationships with men, difficulties in mothering, bad feelings about their bodies, childishness, and dependency; (5) the problems of men are recognized by staff as no job training, being passive, and lacking any desire to better themselves; and (6) a relationship with a man is regarded by staff as important to a woman's successful completion of the program, but, for a man, more weight is given to realistic job plans. A comparison of the stated problems of residents with the staff members' perceptions of their problems revealed a number of differences and raised questions concerning staff ability to perceive accurately and, to deal with the problems of clients generally and women particularly. Residents reported significantly more concerns than staff over lack of job training, poor family relationships, poor relationships with the opposite sex, childishness, lack of education, suicide attempts, dependency, bad feelings about body, prejudice, and not feeling smart. For women, lack of job training, bad feelings about body, suicide attempts, and not feeling smart were among the statistically significant discrepancies between staff members' and patients' own perceptions of problems. Although male and female staff members do differ in their use of the range of the Attitudes Toward Women Scale, there is no statistically significant difference between the groups. The authors conclude that the therapeutic community is as unresponsive as most of society to the special needs of women. They suggest that if real progress is to be made for female clients, changes must be made in the social and clinical practices of all staff members.

139.

Pattee, Christine. Population characteristics and sex-role patterns in a youth-run crisis center. ***Journal of Youth and Adolescence*, 3(3):231-246, 1974.**

A youth-initiated and operated crisis counseling center, Number Nine, was studied by participant observation from September 1 to December 31, 1970. A short standardized data schedule was completed for 285 people, including all staff members and almost every other individual who visited the center during this period. The goals of the study were to: (1) establish a demographic profile of the total population of a youth-operated crisis center; (2) compare the characteristics of staff and nonstaff; and (3) examine the extent to which Number Nine succeeded in breaking out of traditional therapeutic and sex-role patterns. There were no appointments, applications, or fees at Number Nine. As community spirit was emphasized as much as counseling, visitors did not have to define themselves as sick or needing help. The population was predominantly white, with slightly more males than females; 36 percent of the youths were from working or lower class backgrounds; the age level was young (median, 19.4 years) but not exclusively adolescent; over half the population had had contact with a mental health professional at some level; and a substantial proportion had been hospitalized or in outpatient therapy for long periods of time. The staff was significantly older, more educated, and of a higher social class than nonstaff, and a significantly larger number of staff members had had mental health contact and were living in a nonfamily situation. The nonstaff included frequenters, mostly male, who "hung around" and were not counseled; counselees, mostly female, who were counseled at least twice; and drop-ins, evenly divided between males and females, whose contacts with Number Nine were brief. Almost all problems, 94 percent, were counseled. Of the youths coming in for general reasons, 52 percent were counseled, as well 19 percent of those who came to give help. Over half of the males but only one-fourth of the females were not counseled, a highly significant difference. Females were more likely to say that they had a problem and significantly more likely to be perceived as having one. In contrast, males were reluctant to present themselves as having a problem and significantly less likely to be perceived as having one. In her discussion, the author focuses on the deleterious effects of these different patterns on both male and female youths. She points out that individuals at Number Nine, working to break out of stereotypes, were less aware of and, consequently, less successful at changing sex-role stereotypes. Number Nine was considered a community and a counseling center, but "females got the counseling and males got the community." Pattee also discusses race and class at Number Nine and differences between staff and nonstaff.

140.

Pemberton, D.A. A comparison of the outcome of treatment in female and male alcoholics. ***The British Journal of Psychiatry,*** **113(497):367-373, 1967.**

Outcome of treatment was compared in 46 female alcoholics and 43 male alcoholics. The subjects were those individuals who could be located out of a group of 50 men and 50 women who had been patients at Crichton Royal Hospital in England. The men had been hospitalized during 1963 and the women between January 1963 and February 1965. The two groups did not differ in age at hospital admission, age at onset of drinking, years of addiction, number of hospital admissions, or treatment received (i.e., routine or intensive psychotherapy). The following psychological tests revealed no significant differences between the males and females: Maudsley Personality Inventory, the Sixteen Personality Factor Questionnaire, the Raven's Matrices, and the Mill Hill Vocabulary

Scale. Despite the overall similarity between male and female alcoholics, females were less successfully treated. "Success" was defined as either abstinence or one or two occasions of having a drink, and was reported by the patients at the time of the follow-up study. Supporting information was obtained from a relative whenever possible. Success was not related to the time elapsed since hospital discharge. Ten of the 46 women and 18 of the 43 men were categorized as successful. There were a number of statistically significant differences in the factors related to success for the male and female groups. Disturbed marital status and frequent hospital admissions were related to failure for women but not for men. Intensive treatment was related to success for females but not for males. Introversion, anxiety, and submissiveness were related to the women's success; anxiety and introversion were related to the men's failure. Absence of intellectual impairment and a diagnosis of neuroticism as the cause of alcoholism were related to success in both male and female groups. In addition to the statistically significant sex differences noted above, the authors reported a number of differences in clinical impressions. All of the females had been secretive drinkers at one time, and none of the males had been. Females were secretive about their drinking problem on the ward, whereas men were open about their difficulty. Successful females had all modified their family structures so as to provide a personally satisfying role for themselves. The authors hypothesized that "females find it more difficult to establish a satisfying role for themselves within their familial unit because of either an openly critical husband or a more severely disturbing illness, or a failure to adapt to the loss of a husband."

141.

Stein, Leonard S.; Del Gaudio, Andrew C.; and Ansley, Martha Y. A comparison of female and male neurotic depressives. *Journal of Clinical Psychology*, 32(1):19-21, 1976.

A comparison of the type and amount of treatment provided to males and females who had received a diagnosis of neurotic depression is reported. Subjects were drawn from a pool of 92 outpatients at the University of Rochester Community Mental Health Clinic who agreed to participate in the research. Of this group of 129 females and 63 males, 30 females and 14 males were diagnosed as neurotic depressive. There were no sex-related differences on the dimensions of age, race, marital status, or education for the 44 individuals. The relationship of type and amount of treatment to self-reported severity of disturbance was also examined. Twenty scores were obtained from the Terminator-Remainer Scale, the Hopkins Symptom Rating Scale, the Psychiatric Out-Patient Mood Scale, the FIRO-B, and the Crowne-Marlowe Social Desirability Scale. An analysis of differences between males and females in each of the 20 measures of degree of disturbance revealed only one statistically significant difference. The authors conclude that there were no significant differences in patients' self-ratings. All of the male patients and 28 of the 30 female patients were assigned to individual psychotherapy. The two remaining women received group therapy. The average number of visits was 7.85 for males and 10.80 for females; this difference was significant at the .05 level. Psychotropic medication was provided for 5 of the 13 men from whom data were available and for 18 of the 30 women. Antidepressant medications were given to 36.7 percent of the women as compared to 7.7 percent of the men. Both of these differences were statistically significant ($p < .10$ and $p < .05$, respectively). The authors conclude that although the self-descriptions of men's and women's symptoms, moods, and interpersonal behaviors do not differ, women are seen for significantly more therapy sessions and treated significantly more often with potent antidepressant medication. They suggest that future study should focus on therapists' differential attitudes toward and treatment of males and females.

Overviews of Research

142.

Hill, Clara E. A research perspective on counseling women. ***The Counseling Psychologist*****, 6(2):53-55, 1976.**

The articles about the counseling of women published in this issue (*The Counseling Psychologist*, Vol. 6, No. 2) are critically examined by Hill. Her analysis relies upon the traditional criteria of psychotherapy research: client variables, counselor variables, independent or treatment variables, and dependent or criterion variables. She notes the high variability in clients' response to treatment that is evident in the data from counseling research. Hill points out, however, that research has failed to establish that female clients act differently than males or that counselors treat them differently. She suggests that this may be the case because researchers are not studying the relevant variables. Differences in treatment may not be due simply to gender, because there is such a large amount of variability among women. There is a need for client variables to be specified more clearly; research has focused too much on women as a homogeneous group rather than as a group with many different characteristics and problems. The author asserts that it is crucially important to determine how the differences between women affect the process and outcome of counseling. In discussing counselor variables, Hill identifies the need to specify counselor variables more clearly—instead of merely dividing them according to sex—and to define explicitly the terms used to describe counselors such as sensitivity and empathy. The counselor's stage of cognitive development in her/his attitude toward women may prove very important in predicting sexism and bias in counseling. Hill asserts that research must be conducted to determine how to train counselors (1) to become more aware of and to change behavior that is inappropriate or harmful for women and (2) to counsel specific subgroups of women. In dealing with treatment variables, Hill notes that specific treatment interventions for women's specific problems, such as rape and abortion, are discussed in this issue, but that none of the authors offer empirical evidence about the efficacy of their approaches. Without this evidence, there is no scientific way of

knowing if these treatment programs are any more effective than traditional treatment or no treatment at all. The components of these treatments need to be tested to establish which factors account for what changes. Other factors that influence treatment, such as support from significant others, must be explored to empirically establish that the treatments are effective. Finally, in examining criterion variables, Hill points out that the available measures for evaluating treatment effectiveness have limitations for use with women. She maintains that treatment programs must specify their desirable outcomes so that appropriate measures can be used to determine effectiveness, noting that it is difficult to tell what the desired outcomes are in the treatment interventions for women, since they are usually not specified. In that individuals have different goals, Hill suggests that instruments be used that measure individually designated behaviors and goals. She concludes that her criticisms represent challenges researchers must face if the effects of counseling interventions for women are to be studied.

143.

Klein, Marjorie H. Feminist concepts of therapy outcome. *Psychotherapy: Theory, Research and Practice*, 13(1):89-95, 1976.

Klein examines how sex-role bias is reflected in outcome measures used to evaluate therapy. She reviews several of the commonly used concepts—symptom removal, self-esteem, quality of interpersonal relationships, role performance, target problems, and problem solving—which reveal the differences between traditional and feminist views of mental health. Feminist therapy stresses the importance of realizing one's uniqueness in the social context, in contrast to the emphasis of traditional therapy concepts on adjustment to generally accepted role definitions. Therefore, many traditional outcome evaluations judge women primarily in housewife or parental functions. If the woman works full time, her job functioning may be evaluated without sufficient attention to such factors as personal growth in the job or possible discriminatory conditions. Interpersonal relationships may be assessed in terms of maternal ideals, and necessary assertive skills may not be rated as desirable. Most indices stress symptom removal and alleviation of pain, but women may feel necessary "growing pains" as they expand their horizons. Further, the responsibility for symptoms is traditionally seen to reside in "neurosis" rather than in frustrating life circumstances. Measures of target problems are also biased;

a woman's perceived problems may actually involve her family and be insoluble on an individual basis. Self-esteem is often assessed by comparing self-image to ideal personal or consensual images that are influenced by sex-role stereotypes. A feminist perspective would determine the degree to which the self-image is autonomous and internally anchored. Instead of focusing on sexual performance, therapy outcome measures might include the concept of body image and sensuality. An assessment would be made of a woman's development of a positive perception of her body and an acceptance of responsiblity for knowing and managing her sexual and reproductive processes. Klein also includes political awareness and action as new but important criteria for therapeutic growth. She maintains that if the goal of feminist and humanist therapy—enabling the patient to successfully choose and adapt roles to fit personal needs—is to be realized, accurate, unstereotyped outcome measures are necessary. Klein concludes with a checklist of feminist goals, suggesting that these are things that every therapist should ask about female patients and every researcher should consider.

144.

McEwen, Marylu K. Counseling women: A review of the research. ***Journal of College Student Personnel*, 16(5):382-388, 1975.**

McEwen attempts to examine recent research support for the major recommendations concerning the counseling of women that have emerged from the feminist movement. Based on her review of studies on counselor perceptions of male and female clients, McEwen concludes that both male and female counselors exhibit sex bias. She suggests that counselors be encouraged to examine sexist attitudes and their effect on counseling women. Studies that would assist counselors in becoming aware of biases and in learning skills for nonsexist counseling are cited. Studies focusing on sex bias in career counseling are also summarized. Since these studies reveal that both male and female counselors are misinformed about women and work, McEwen recommends that more accurate information be acquired. She interprets the research in this area as suggesting that counselors should be chosen on the basis of their lack of bias rather than for their sex. McEwen cites 27 studies which indicate that women pursuing higher education or careers often experience role conflict. Women also appear to exhibit a phenomenon first defined by Horner (1969) as M-s, or motive to avoid success. Research suggests that career development is a less significant factor in women's early development than in men's and that programs should be designed to enhance this factor and help women relate career choice to their total lives in a way that reduces role conflict. Studies on approaches to career planning for women show that career modeling and expectations from faculty and administration positively affect the aspiration levels of women college students. McEwen suggests that counselors need to expand and strengthen these effects. Based on studies dealing with the mature woman who returns to school, she further recommends that counselors encourage the development of continuing education programs and help women to become involved in them. McEwen concludes that research in counseling is meager and suggests that less rhetoric and more applied research on programs for women are needed.

145.

Mednick, Martha T. Shuch, and Weissman, Hilda J. The psychology of women—Selected topics. *Annual Review of Psychology*, **26:1-18, 1975.**

This survey of recent literature reviews work in three areas: the psychological study of sex roles, achievement motivation in women, and the impact of feminist thought and knowledge about female sexuality on the theories and practice of psychotherapy. Mednick reports that the psychological study of sex roles has moved from description and acceptance of givens to a concern about the dynamics and implications of change. Questions are also being raised about the social institutions that perpetuate sex roles. Special attention is given to studies on sex-role identity, and research on sex-role stereotypes is also reviewed. In presenting the work that has been done on achievement tendencies in women, Mednick notes that until 1971 studies on achievement motivation were solely concerned with men. Discussing the studies on women's fear of success that have been conducted since Horner (1972) posited this idea, she concludes that although this concept has stimulated a new look at the subject of achievement, the measure and concept need to be refined so that there can be adequate testing and modification of the theory. Studies about women's expectancies and causal attributions relating to their success and failure are also discussed. In introducing her review of the literature relating to psychotherapy for women, Weissman indicates that there has been more speculation than empirical work. She reports on the strong stand taken by radical feminists who maintain that traditional psychotherapy is destructive to women's human potential and lists some of the many therapy substitutes that have arisen, such as consciousness-raising and assertiveness-training groups. Although there has been considerable theoretical discussion by professionals of the issues raised by the feminists, Weissman indicates that there has been little systematic development or research on theory or practice. Research on women is most often in the areas of abortion and frigidity. Weissman reports on the promising developments and critical rhetoric in psychoanalytic thought, noting that this appears to continue to be the most influential theoretical basis for treatment in clinics and private practice. Criticism of Freudian theory has received greatest recent impetus from the work of Masters and Johnson and of Sherfey, which completely contradicts much of Freud's theory of female sexuality. Studies that point to man's greater vulnerability both physically and psychosexually are cited, and Weissman identifies movement on the part of various disciplines toward revising this culture's androcentric epistemology.

146.

Oliver, Laurel W. Counseling implications of recent research on women. *Personnel and Guidance Journal*, 53(6):430-437, 1975.

This article surveys some of the recent research on women and, on the basis of this research, makes some generalizations that are identified as potentially useful in counseling. Counselor bias is the first research area considered, and studies are cited showing a sexist bias in counseling content and counseling style. The use of sex-stereotyped tests and occupational information is also discussed. The research is said to imply a need for counselors to guard against tendencies to consider psychologically unhealthy traits appropriate for women and untraditional career choices unwise for women. Counselors should work to find nonsexist tests and career information and be certain they are treating each client according to individual needs rather than on the basis of sex. Research on demographic changes shows that women are remaining single longer, having fewer children, and either working while their children are young or returning to schools or jobs when their family responsibilities ease. On the basis of these findings, the author suggests the importance of better guidance for younger women and the need to provide counseling for those women who want to continue their education or reenter the work force. Studies on sex differences are cited with particular emphasis on the differences in achievement motivation between men and women. Matina Horner's work on fear of success (1970, 1972) is discussed as is Baruch's (1967) concept that women may have a cyclical achievement motivational pattern. Counselors are urged to explore with their clients possible conflicts about success and be aware of the possible effect of life stage on motivation. Cited next are studies on sex-role stereotypes that deal with the following concepts: that women's negative self-concept is related to the fact that the male stereotype is regarded more positively; that women who view themselves in nontraditional ways are psychologically healthier than other women; and that career women do not necessarily reject the feminine role. Other ideas pertaining to changing sex-role stereotypes are also mentioned. Although well-defined sex stereotypes still exist, the evidence is that women's thinking is becoming less and less traditional. Research on role stereotypes suggests that counselors must remain aware of the current sex-role stereotypes and understand that changes in sex roles can be expected. They must recognize the fact that women may be uncomfortable during this period of change and may need help in resolving career-marriage conflicts. In conclusion, the author provides several specific suggestions for counselors who want to increase their sensitivity to the issues raised by recent research on women.

147.

Seiden, Anne M. Overview: Research on the psychology of women. II. Women in families, work, and psychotherapy. *American Journal of Psychiatry*, 133(10):1111-1123, 1976.

In this second overview of research on the psychology of women, Seiden focuses on family structure and child rearing, women at work and in the community, and the impact of recent research on the clinical treatment of women. The author provides a picture of the nuclear family, indicating that child care responsibilities fall heavily on women and that mental health statistics reveal married women to be more likely to seek psychiatric help than single women. Discussing the causes for this phenomenon, she suggests that it is important for clinicians to have a realistic appraisal of the occupational hazards of child rearing and the need for support and backup. Seiden provides an overall view of women at work and their special burdens, and she notes the extensive body of research on motivation in women, working conditions of women, and the effects of a mother's outside employment on children. Additionally, she reports on a growing body of research on the subject of female-to-female social networks that has been neglected by social theory until now. In dealing with the impact of recent research on the clinical treatment of women, Seiden initially indicates that research on depression has shown a marked similarity between the learned helplessness model of this disease that afflicts so many women and the stereotypical feminine role. She also discusses the effects of rigid sex roles in relation to schizophrenia. Seiden points out in her review of psychotherapy research that current feminist effort has brought the question of the adverse effects of psychotherapy to the fore, and she lists the specific trouble areas that feminists have identified. Seiden discusses research on issues related to the therapist's gender, noting that there is little solid information on differential outcomes by diagnosis and other patient characteristics. She deals with issues in the training of therapists that are likely to affect the way male and female therapists work with their women clients and suggests that the therapists may need continuing education and consultations to help them keep up with the new problems that will arise with changing roles and expectations. In discussing the effects of the women's movement on clinical treatment, Seiden indicates that economic issues may be one explanation for professional suspicion concerning feminist therapy and its clientele. The characteristics and goals of feminist therapy are presented, and its risks are identified as neglect of internal conflicts and general inability to medically treat organically determined disorders. In a discussion section Seiden deals with the need to process the large body of research on women so that an appropriate theory of women can be formulated. She presents the reasons for her belief that this body of research can help in the development of new constructs that will account for social factors in psychopathology. Seiden predicts that in future research particular attention will be given to areas that bear on women's lives.

148.

Tanney, Mary Faith, and Birk, Janice M. Women counselors for women clients? A review of the research. *The Counseling Psychologist,* 6(2):28-32, 1976.

Tanney and Birk briefly review current empirical literature dealing with the impact of the sex of the therapist/counselor on the woman client. The first body of research reviewed concerns client reactions to therapist sex. Two studies are cited that show women prefer to see female therapists for personal problems; a third study is mentioned that indicates women generally rated therapy with women more satisfying than therapy with men. The authors note that research about the female client's preferences for male or female counselors is sparse. The literature that does exist is presented as contradictory and confusing because of the selection of different populations and use of different instruments. Far more research has been devoted to the subject of counselors' attitudes about sex-role stereotypes and their judgments of mental health. The literature reviewed indicates that the judgments of mental health professionals on the appropriateness of certain behaviors and needs are often influenced by the sex of the subject. Other studies cited focus on the differences in male and female therapists' perceptions of clients. All these studies make the assumption that the therapists' attitudes will be conveyed in therapy, and only one study was found that attempted to measure behavior correlates of therapists' attitudes toward women. Research on sex bias in career counseling is also presented. Most of this research found that both male and female counselors are biased toward traditional career choices for women. On the basis of the literature reviewed, the authors report that researchers are becoming more sophisticated. They suggest, however, that additional areas of measurement need to be explored, beyond client self-disclosure and satisfaction, to clearly describe the impact of therapist gender on women clients. Women clients' perceptions and preference for sex of counselor need to be carefully monitored. They note that in spite of conclusive empirical findings, psychologists continue to theorize on this topic. The authors point out that this particular area of research is very reactive and may be complicated by the fact that now the desirability of viewing male characteristics positively has been replaced by the desirability of appearing to be free of sex stereotypes. The new sensitivity to sex bias is seen as making the research complications worthwhile. The authors conclude that training programs need to emphasize new knowledge about the psychology of women and that counselors need to sensitize themselves to sex stereotyping in any form.

149.

Waskow, Irene Elkin. Research on psychotherapy with women: A workshop introduction. Summary of discussion following workshop. ***Psychotherapy: Theory, Research and Practice*****, 13(1):64-65, 96-98, 1976.**

In the introduction Waskow points out that the five articles included in this collection and published in this issue of *Psychotherapy:*

Theory, Research and Practice are revised and edited versions of papers presented at a workshop on "Research on Psychotherapy With Women: Traditional and Alternative Models" that was held at the June 1974 meetings of the Society for Psychotherapy Research. Discussing the background and purpose of the workshop, Waskow notes that in the last few years the Women's Movement has raised several questions concerning the mental health field and psychotherapy with women as traditionally practiced. Alternatives have been developed which challenge current treatment approaches and which provided the stimulus for this workshop. Effort was focused on research on psychotherapy and on alternative models. The workshop premises were that (1) the Women's Movement has identified many important issues which therapists and researchers should seriously consider, and (2) it is feasible to conduct research which can at least partially respond to meaningful questions in this area. Indicating that there has been only a small amount of research concerned with therapy-related questions, Waskow notes that two major directions for research are reflected in the five presented papers: (1) studying alternatives to therapy, such as "feminist therapy," consciousness-raising groups, and women's self-help groups; and (2) looking at more traditional forms of therapy and research on them in terms of the issues raised by the Women's Movement. Waskow identifies the authors of the five articles and their subjects: (1) Diane Kravetz* discusses the effects of consciousness-raising groups, suggesting directions for research on consciousness-raising groups as an alternative to psychotherapy; (2) Marilyn Johnson* reports on an exploratory study conducted by the Feminist Therapy Collective in Philadelphia; (3) Kristin Glaser* presents the findings of her two group interviews with participants in a women's self-help group; (4) David Orlinsky and Kenneth Howard* provide a reanalysis of the data in their study of psychotherapy with women patients, examining differences in therapeutic experiences due to the sex of the therapist; and (5) Marjorie Klein* offers an analysis, based on a feminist perspective, of criteria used to evaluate therapy outcome. In the summary section Waskow elaborates on the five major themes that emerged in the Workshop discussion following the presentation of these papers—the existence of sexism in traditional psychotherapies, role of sex of therapist vs. therapist's attitudes and ideology, biases in outcome criteria used in research, comparisons of different treatment models for women, and values and social issues.

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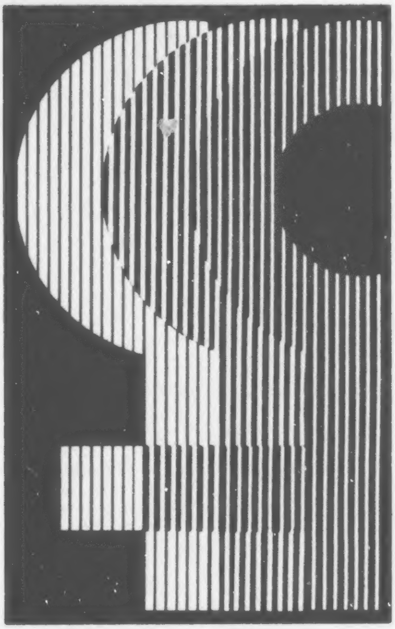
*Abstract of article included in this bibliography.

IV.

RESPONSE TO CRITICISM—MODIFICATIONS OF THERAPY AND NEW APPROACHES: THEORY AND RESEARCH



Women Therapists and Women's Groups for Women Patients

Other Responses, Modifications of Therapy, and New Approaches

Women Therapists and Women's Groups for Women Patients

150.

Bradner, Patty. Women in groups. ***American Journal of Nursing,*** **74(9):1661-1664, 1974.**

A mental health nurse therapist reports on the "Who Am I" series she and a co-therapist established. This primary prevention program for women is offered as one of the programs of the Women for Change Center in Dallas. Advertised as a "forum to enable women to help themselves and each other," this group, which charges low fees, offers women some help before more extensive and expensive therapy is required. The atmosphere created for the group sessions is described as homelike and comfortable, more like a social gathering than a therapy session. The goals of each of the four 2-hour sessions and the reactions of the women are described, and some specific responses of women from one series of sessions are related. A reading list is distributed to the women as a supplement to the sessions and as a means of familiarizing them with the ideas and values of other women. Additionally, they are given a "Choices" list of activities and involvements for women in the community that offers them the opportunity of using their skills and talents. In the first meeting the objective is to stimulate the women to think about a woman's individual identity in today's society. The second session begins with a reading of the "self-likes" list the women were asked to prepare during the week between sessions. As mutual acceptance and support become apparent, the women risk being more open about themselves and their feelings. In the third session, the focus is on problem solving. The therapists point out to the members that a problem should be defined clearly and the choices and consequences considered before a decision is made. When a problem seems overwhelming to a woman, the group can help her redefine it and assist her in making more appropriate choices. The women are encouraged to establish goals for themselves. As some women refuse to set goals because they fear success can lead to more responsibility and greater risk of failure, time is spent dealing with this cycle of fear. At the last meeting the women typically express a sense of loss, and the therapist encourages optimism with a discussion of future plans, aided by the "Choices" list.

151.

Carlock, Charlene J., and Martin, Patricia Yancey. Sex composition and the intensive group experience. *Social Work*, **22(1):27-32, 1977.**

A detailed report is given of a study designed to determine the effects on female participants of the sex composition of growth-oriented groups. Focus was on how the behaviors, perceptions, and emotional experiences of female group members may vary in all-female and male-female groups. A group of nine women and a comparison group of eight men and eight women (two women members of the mixed group dropped out) participated in 37 hours of group experience that was a variation on a marathon group format with the same two facilitators, who emphasized their roles as co-learners. The leaders had a feminist orientation and their theoretical approach was eclectic, drawn mostly from gestalt, contractual, and client-centered therapies. The applicants had responded to advertisements for intensive weekend sessions designed to help break down rigid sex-role barriers and deal with sex-role issues and the problems of both men and women. After initial screening, 17 women were selected and randomly assigned to one of the two groups, and 8 men were selected and assigned to the mixed group. The Personal Orientation Inventory (POI), the Group Inquirer (GI), and the Sex-Role Questionnaire (SRQ) were the data collection instruments used. Additionally, open-ended interviews were held with each female group member before and after participation in the group sessions; journals were kept by both female and male participants during the sessions; and postweekend interviews were held with at least one significant other person in the life of each female group member. The authors report significant positive gains for women in the all-female group on three specific POI dimensions—the women became less other directed, .09; more innerdirected, .13; and more accepting of their own feelings of aggression, .01. In contrast neither the women nor the men in the male-female group showed significant positive changes on a single POI dimension. Data from the GI instrument reveal that women in the all-female group were slow to develop group involvement, and the intensity of their involvement never exceeded a moderate level. The women in the male-female group demonstrated a high level of emotional intensity but never became secure enough to express their true feelings or to develop trust in other group members, and they tended to assume the role of observer. Analysis of journals kept by group members and leaders revealed that the women in the all-female group apparently competed with each other very little in contrast to the women in the mixed group who appeared to have spent a major portion of the weekend in competition with each other for male attention and approval. The authors also discuss the distinctions observed between the two groups in the development of intimacy, closeness, and feelings of sexual attraction or repulsion. Only for women in the all-women's group did the SRQ results reveal a decrease in the discrepancy between how they saw themselves and how they wanted to be during the period between the preweekend sessions and the second followup sessions with regard to both male and female characteristics. At all measurement points and for both male and female characteristics, the men revealed a much smaller discrepancy than the women between how they perceived themselves and how they would like to be. The quantitative data reveal that women in the all-female group experienced the greatest gains of all participants. The authors discuss the implications of these results for group leaders who may choose to have members of one or both sexes in their program depending on their goals. Finally, they conclude that the data indicate that all-female personal development groups can have positive results for their participants. A need is identified for further research in order to fully understand the effects of sex role and sex composition on group outcomes and to correct for the discrepancy in the size of the two groups in this study.

152.

Carter, Charlene A. Advantages of being a woman therapist. *Psychotherapy: Theory, Research and Practice*, 8(4):297-300, 1971.

Carter points out that a woman's developmental experiences better prepare her for being a therapist than do a man's. In response to social role expectations, girls are interested in people and relationships and in giving emotional support. Understanding, nurturance, and responsiveness in women are valued and rewarded. The sexual identity of therapists is part of their equipment, and, as a result of biology and sex-role training, men and women therapists will perceive things differently. Men therapists work from a cognitive framework while women operate on the basis of their feelings. Although some patients may be helped by the cognitive approach, the author claims that more people seek therapy because they are confused about their emotions, and that women are better equipped to understand emotional realities because of their social training. Carter maintains that women are particularly well suited for dealing with several types of patients. Severely disturbed patients benefit from a woman therapist, because the therapeutic relationship can help to free them from the distortions of their original mother-child relationship. A woman therapist is needed in the treatment of a female delinquent to help her establish a sexual identity, serve as a model, and provide nurturance. Carter also feels that women can treat post-adolescent women facing developmental crises better than male therapists, since they have gone through the experience themselves. She points out that women therapists are especially effective in working with female hysterics, because the hysteric's sexual defenses are ineffective with a woman therapist and because a female therapist cannot be misled by protestations of helplessness and inadequacy. Also, a female therapist is better able to resolve the mother-daughter relationship that is the hysteric's central difficulty, by offering nurturance and acceptance. In conclusion, Carter suggests that therapy employing both men and women therapists with their different perceptions and strong points could be especially effective in working with neurotic patients.

153.

Goz, Rebecca. Women patients and women therapists: Some issues that come up in psychotherapy. ***International Journal of Psychoanalytic Psychotherapy*****, 2(3):298-319, 1973.**

The thesis of this paper is that the request by a woman for a woman therapist, even when couched in terms of women's liberation, is nearly always a disguised request to "duplicate, review, reinstate, reenact, repair, and recreate some powerful unresolved tensions in her relationship to her mother. . . ." According to Goz, the presence of a female therapist in short-term psychotherapy enhances the likelihood that this will occur. Clinical examples derived from her own therapy with patients are presented to show how women patients in three areas of female development can work to special advantage in treatment with women therapists. The first area of female development dealt with is pregnancy. Goz describes how her own pregnancy aided in the therapy of a woman whose emotional responses to an unwanted pregnancy were playing havoc with her life. The second area of development presented is symbiosis, or the wish for exclusiveness in the relationship between mother and child. The first case presented is of a woman who was having vivid symbiotic struggles with her young baby, unable to separate herself from the child, but at the same time wanting a separate life. The patient's relationship with Goz enabled her to reenact some aspects of mother-daughter tensions and to express and clarify her conflicts and feelings about her mother. Goz suggests that women with conflicts about motherhood and career can find therapy valuable, not only for discussion of alternatives but for bringing about an awareness of the origin of the conflict. Another case is presented in which the patient's relationship with Goz enabled the client to work through some problems arising from her relationship with her mother and to understand the basis of her disturbance. Homosexuality is the third area dealt with, and Goz contends that a major (but rarely stated) reason women want female therapists is to talk about their sexual feelings toward women. Goz suggests that homosexual concerns often go untouched in treatment, because they are so well disguised. In the first case presented, homosexuality was never mentioned. Now, reflecting on the course of the therapy, Goz believes that an understanding by the patient of her homosexual preferences and desires would have been very valuable. In the second case, a woman concerned about homosexual feelings was able to better understand her relationship to her mother and perhaps the source of her homosexual feelings by relating to the therapist who was pregnant at the time. In the final case presented, a woman whose previous therapy had focused on her relationships with men was able to find some relief from tension and was able to discuss her troubling homosexual feelings and fantasies and her "homosexual interaction" with her mother. Although therapy was terminated after only five sessions, the patient was able to return to her work and renew her relationship with her father.

154.

Halas, Celia. All-women's groups: A view from inside. *Personnel and Guidance Journal*, 52(2):91-95, 1973.

Halas attempts to provide a rationale for all-women's groups and, if possible, to dispel some of the mystery and the threat from the prospect of women getting together without men. She stresses that all-women's groups are extremely helpful for many women and should be encouraged. Similar themes are identified among women clients, regardless of their presenting problems—feelings of isolation, alienation, worthlessness, loneliness, frustration, helplessness, and low self-esteem. Halas states that women's groups meet many needs and elaborates upon the dynamic variables that make mixed-sex and same-sex groups different. In a mixed group, with a masculine model of competence dominant, women are reinforced for the stereotypical role of dependence, submissiveness, and receptiveness. Women who have rejected this stereotype in their own lives are reluctant to discuss among men their problems of dealing with feelings of strength, power, independence, jealousy, sexuality, and identity. Halas notes that given a little impetus, women's counseling groups seem to evolve naturally. Among the benefits of all-women's groups are that they give women the opportunity to look at themselves, their goals, and their achievements in relation to the double bind inflicted upon them by society. Women need to talk in an understanding and accepting atmosphere about their conflict between internalized desires to marry and have children and to achieve in a competitive work situation. A recent experience with women in an adult education program, illustrating what happens when women get together in groups, is recounted. Halas contends that the enculturation of women disposes them to find an all-women's group more facilitative. In that their self-esteem is derived from the acceptance and love they feel from others, women find risking in a mixed group difficult. She indicates that women do need to risk and examine their feelings about having "feminine" and "masculine" qualities. They need to deal with the ways these stereotypes have worked for and against them and develop new behavior. The sense of isolation, alienation and worthlessness that many women feel is often an issue in the groups, with the women finding it less threatening to focus on the source of their feelings, express their anger, and cry among accepting peers. In contrast to what happens in mixed groups, a high level of trust develops quickly in women's groups. Although women are concerned about this sexist society and may appropriately recognize and express their anger, Halas points out that it is a misconception that women's consciousness-raising groups focus on hating men. In concluding, Halas suggests that research is needed to explore the unique contributions of women's groups.

155.

Killeen, Maureen R., and Jacobs, Caroline L. Brief group therapy for women students. *Social Work,* **21(6):521-522, 1976.**

The authors describe a university health service's brief group therapy program designed specifically to deal with the special developmental problems of women. Therapeutic intervention was proposed to respond to the students' role and identity conflicts as well as to the problem of depression. The program's goals are identified as (1) offering women the opportunity to discuss mutual difficulties in a group setting and (2) providing a healthy opportunity for female students to relate to one another without the perceived threat of evaluation by men. During the past year 40 women have met weekly in groups of 8 for about 8 sessions with 2 female therapists, a psychiatric nurse and a psychiatric social worker. During the initial visit, most women present one or more of the following complaints: feelings of depression; some form of disruption in a relationship with a man; and a pervasive, vague feeling that something is wrong in their interpersonal relationships with peers. The women usually refer to feelings of loneliness and low self esteem and specify that the social environment and their relationships with others are not meeting their needs. The authors discuss the group process, noting that members are encouraged to be direct and to communicate honestly about feelings and desires. New behaviors are tried within the group and trial outside is encouraged. To stimulate risk taking and change, the group discusses and positively reinforces appropriate behaviors that the women previously avoided. The active part the female leaders play in dispelling myths about men is identified as a positive aspect of women's groups, and Polster is quoted to confirm the advantages of systems in which women help other women. All group members have reported improved communication with their parents, men and women peers, and increased communication and positive regard for their mothers. The authors conclude that brief group therapy is an effective treatment modality for intervention in the situational and neurotic problems of women students. They recommend its use in college counseling centers and mental health clinics as a preventive approach to the developmental problems of women students.

156.

Kilmann, Peter R.; Follingstad, Diane R.; Price, M. Gail; Rowland, Kay F.; and Robinson, Elizabeth A. Effects of a marathon group on self-actualization and attitudes toward women. *Journal of Clinical Psycnology*, 32(1):154-157, 1976.

The authors hypothesized that women participants in a marathon group designed to increase individuality, self-expression, and independent thought and action would become more self-actualized (defined in terms of independence and orientation toward the present) and would shift toward greater agreement with generally accepted tenets of the women's liberation movement. Subjects were 28 female undergraduate volunteers randomly assigned to one of two marathon groups run by four female predoctoral candidates, two in each group, or to a no-treatment control group. Shostrom's Personality Orientation Inventory (POI) was used to assess self-actualization in terms of time competence and inner-directedness, and the Attitudes Toward Women Scale (AWS) investigated traditional versus contemporary, profeminist responses to questions about women's rights and roles. Testing was done before the marathon and 1 day and 5 weeks after the marathon. Pretest scores indicated a significant relationship between profeminist attitudes and both present time orientation and independent outlook. Combined marathon groups had a significant pre- to posttest change in inner directedness. The authors report that in one marathon group, there were significant increases in AWS scores toward a profeminist position at 1-day posttest and at 5 weeks. A possible explanation of the lack of change on the AWS in the other marathon group was its lower ratings of group climate. Leaders also reported that members of this group were less interested in women's issues. The authors point out that both 16-hour marathon groups did, however, facilitate significant increases in independence as measured by the POI scale.

157.

Lynch, Carmen. Women's groups. ***Family Therapy*****, 1(3):223-228, 1974.**

Lynch suggests that there are specific, readily described women who can benefit from a women's therapy group. She identifies these women and their needs and discusses how group, rather than individual, therapy can help them. The group gives women who need mothering a much wider base of female support and nurturing. A variety of models from which a woman can begin to develop her own female identity are available for women who do not enjoy being female. For women who are professional victims, an all-women's group has the potential of neutralizing the power struggle these women create with a therapist. The group offers support and sympathy along with confrontation from other victims or ex-victims. A women's group can serve as a bridge between the old and new life that women who are getting little validation and support are trying to develop for themselves. Women who are experiencing sexual difficulties may feel more comfortable discussing and learning about sex in a women's group, and, additionally, the group may help reduce their feelings of isolation and loneliness. The group allows women who are fearful of homosexuality, the opportunity to experience other women and deal with the issues in a safe environment. An all-women's group can help women who are closed off from their feelings to open up, hear how they come across to others, and get in touch with their defense structures. Women who have no female base may build an identity more quickly in a group than in an individual setting, for all the women in the group can be used as a model. The group helps these women, for their usual approach of manipulation and seduction does not work with women as it does with men. A support base, a surrogate family of mothers and sisters, and several different models from which to explore and enjoy the functions of adolescence are offered to the women who are reexperiencing adolescence. The group provides continuity and stability as women go through this process. When a women's group is the treatment of choice, it is usually for a limited period of time. Lynch suggests that such an approach is most effective when used with other therapy approaches in different combinations and time sequences. Recognizing that women's groups fulfill an important function in their members' growth and therapy experience, Lynch expresses her belief that not all female patients can benefit from a women's group and that many need a mixed male-female therapy group.

158.

Meador, Betty; Solomon, Evelyn; and Bowen, Maria. Encounter groups for women only. In: Solomon, Lawrence N., and Berzon, Betty, eds. *New Perspectives in Encounter Groups*. San Francisco, Calif.: Jossey-Bass, Inc., 1972. pp. 335-348.

This article examines the value of women-only encounter groups as vehicles for helping women break away from traditional values and role expectations and move toward full development as human beings. The idea for all-women groups emerged from the authors' experiences as women with backgrounds similar to those of the women who would join their encounter groups. The authors describe three major impressions from a year's work of conducting encounter groups: (1) the pleasure they and the women participants experienced just from being with other women; (2) the speed with which women in encounter groups without men are able to discard much of their learned superficial role behavior; and (3) the extent to which these women were reexamining social values and mores despite the fact that women's liberation as such was not a major concern for them. Most of the women participating in the groups discovered that they had been neglecting their own development, and the groups became opportunities for women to find within themselves the direction they wanted to take. The groups responded to painful self-examinations with support, caring, and confrontation. The authors suggest that mixed encounter groups tend to be microcosms of society with its sexist, paternalistic structures and that without men women are freer to examine their role expectations and their relationships with other women. They are also less fearful of expressing their strength. Most of the work within the groups centered on two major problems: (1) women attach their self-identity to their relationships with their men and/or their children; and (2) women have difficulty feeling and expressing their own potency. The authors see the first step toward self-discovery as dispelling the feeling that one's primary identity is related to being someone's wife, lover, or mother. A necessary and often painful aspect of this struggle was allowing one's own feelings to emerge and accepting these feelings as valid expressions of personhood. Once the women acquired some insight into their dependence on others for their identities and the traps they had moved themselves into, they were able to progress to expressing their own potency. Three major areas of development that were explored openly in the groups are discussed — sexuality, motherhood, and childbearing. The women were able to face their feelings of confusion and fear relating to these areas of concern and were consoled by the realization that other women shared their feelings. They also rediscovered the richness of relationships with other women, which they had been cut off from at adolescence when they began to focus on men. The authors conclude that the trusting, supportive atmosphere of the all-women encounter group is a significant approach to helping women see more clearly what their individual alternatives can be in this time of cultural change.

159.

Meier, G. A health-oriented program for emotionally disturbed women. *Social Casework*, 56(7):411-417, 1975.

A report of the health-oriented sessions for women held in an aftercare center for the emotionally disturbed is presented. The group was limited to women, and its health orientation made clear in the hope that some of the more withdrawn women members of the center would be encouraged to participate actively. An attempt was made to keep the program from being too disturbing or threatening. The program objective was to reduce fear and inappropriate behavior resulting from misconceptions about the body, medical services, and other related issues. The development and implementation of this program effort are described. The first meeting was scheduled to deal with general questions about health care for women and female physiology. At this session the public health nurse was presented as the authority, and questions and comments flowed more freely than anticipated. Although contraception was the subject planned for the second session, the discussion focused on the participants' painful experiences with hysterectomies and involuntary infertility. The nurse was able to answer many questions and reassure the women about a variety of related issues. The participants found it meaningful to share painful memories and other experiences, and they voted to make the women's group a regular program of the center. The author reports that this group, which was based on health- and body-related issues rather than on relationship and feelings concerns, seemed to appeal to a wide range of emotionally disturbed women. Recommendations are made regarding the development of this type of program. According to the author, the intention of health-oriented programs should be to enrich ongoing programs rather than to meet specific information goals. It is suggested that health-oriented programs can be easily introduced into such other settings as day treatment facilities or vocational rehabilitation workshops and be of value to many troubled people.

160

Turkel, Ann Ruth. The impact of feminism on the practice of a woman analyst. *The American Journal of Psychoanalysis*, 36(2): 119-126, 1976.

A woman analyst discusses the changes that have occurred in her practice as a result of the women's liberation movement. She notes that prior to the movement most male and female patients requested male analysts on the basis of cultural stereotyping and distrust of competent females. In contrast, women analysts are now sought by women patients, who sometimes perceive men as hostile oppressors and women as more understanding of their problems. The author's observations are based on her own current female patients, who are described as well-educated and successful career women in their middle to late twenties whose major complaint is their inability to form lasting relationships with men. Although none of the women are actively involved in the women's movement, they demonstrate its impact. Turkel feels that the women's liberation movement must be regarded as a psychosocial movement with significant implications for society as a whole. She suggests that the movement is similar to psychoanalysis in that it is both a search for self-help and a struggle for personal liberation. The movement's influence on her patients is evident in an active, outgoing style of relating to the world and a striving to maintain freedom and to keep options open. No longer do many of the women identify the role of wife and mother as their main goal in life; other needs and activities are as valued and important. Turkel suggests that as women have become stronger and have gained greater respect, as well as increased freedom to express their expectations and dissatisfactions, men have begun to experience more problems with their sexuality. She reports on the particular transference and countertransference problems of the woman analyst working with women patients. Although she feels it is too early to determine what profound effects the women's movement will have on women's hopes and life expectations and on society as a whole, Turkel suggests that the movement which initially has seemed to make women more like men, will ultimately allow them to be more like themselves.

161.

Wolman, Carol S. Therapy groups for women. *American Journal of Psychiatry*, 133(3):274-278, 1976.

Wolman describes her experience of working with two outpatient psychotherapy groups for women. These groups are different from either therapy groups with both sexes or women's consciousness-raising groups. The ongoing sexism that occurs unconsciously in any mixed group is eliminated, and the absence of sexual attraction and games is a helpful simplification. In contrast to the practice with mixed groups, the group members were encouraged to have outside contacts and to provide support for one another. The women who joined these groups differed from women choosing consciousness-raising groups in that they identified themselves as psychiatric patients and were seeking professional help; they had not sought a women's group; and they were not looking for support for the concept that some of their problems are socially induced and occur because they are women. These groups differed from the leaderless consciousness-raising groups in that each group had two women leaders with experience as psychotherapists and group facilitators. Groups A and B were established with a membership varying in size from three to eight. The age range was from 19 to 40; most of the women were single, divorced, or intermittently living with a man. Group A members were mainly lower and middle class women who were working or attending school in contrast to the all middle class B group who were mostly at home. In the initial phase of the groups, the members aired their problems, competed for the therapists' attention, and offered little support to one another. By the middle phase, the groups were well-functioning support systems. Members dealt with problems in giving, receiving, and requesting help; they learned to trust and care about each other, but they became extremely dependent on the group. By the final phase, both groups had only from three to five members. The women remaining in group A, but not in group B, maintained an extremely close relationship. Most of the women in both groups revealed increased self-esteem, and several became involved in new work or educational efforts. Some relationships with men had been dissolved, and others had grown and matured; relationships with children improved. The women learned that masturbation can be helpful, and several became orgasmic for the first time. They began to identify the therapists as professional women who could function as role models in some ways. The author points out that these groups had two problems — there was no heterosexual bonding to keep members in the group when they wanted to run, and the group members' extreme dependence might have been heightened by our culture's equation between "female" and "nurturing" and by the therapists' practice of fostering a support system. Additionally, Wolman identifies the strengths of women's therapy groups — less covert sexism that can be more easily confronted; ability to focus on concerns relevant to women, particularly sexism; increased feelings of safety and comfortableness; experiencing women leaders functioning in authority roles; less need for inhibitory incest taboos; true intimacy developing more readily; and less need for prohibitions on outside contact, which facilitates the development of a support system. She notes that therapy groups for women teach women to respect other women and themselves and offer opportunities to identify common problems, as consciousness-raising groups do, and also have the skilled help of professional therapists available.

162.

Wyckoff, Hogie. Radical psychiatry techniques for solving women's problems in groups. In: Rawlings, Edna I., and Carter, Dianne K., eds. *Psychotherapy for Women: Treatment Toward Equality.* Springfield, Ill.: Charles, C Thomas, Publisher, 1977, pp. 392-403.

Wyckoff describes how the group is used for problem solving in radical psychiatry. The group consists of eight women with one or two facilitators who meet weekly for 2 hours. A contract is considered essential for facilitating work and ensuring that responsibility is equally shared by the individual, the group, and the facilitator. After a contract is drawn up in which the group member identifies an overt behavioral change she wishes to work toward, homework can be given to help her work toward that goal step by step. Wyckoff reports on the necessity of equalizing power within the group from her own experience as a facilitator. For maximum productiveness the facilitator must share herself and be as real and intimate as the rest of the group is expected to be; the women need to understand that the facilitator is fighting the same oppression. Identifying the problem of group collusions in women's groups, Wyckoff points out that the facilitator must break through the group's unconscious agreements not to deal with certain areas. She presents the radical psychiatry technique of giving out "stamps" as a method for demystifying the group process and describes exercises used in the groups to effect change: (1) emotional release exercises, such as bioenergetic breathing; (2) permission exercises—the group facilitator provides permission, protection, and backup strength or potency, so that the group member can do things she has feared doing because of prohibitive parental messages; (3) a group exercise that helps women develop their nuturing parent for themselves; (4) an exercise that helps women in the struggle to "Off the Pig Parent" ("The Pig Parent is the incorporation of all the messages which keep women subordinate"); and (5) bragging—this helps women work on loving themselves and also in destroying their "Pigs," which prohibit them from expressions of self-love. Wyckoff offers several examples of healthy group action in which members cooperate in sharing time, working on each other's contracts, "talking straight" with each other, and trying not to act the part of "Rescuers." The group situation proves very valuable for demonstrating to women that when they work together, they have strength. Wyckoff believes that women must learn to work together and come to love and respect each other. She concludes that complete human liberation is not possible in the present capitalist society, but by working together people may become powerful enough to make substantive changes in the world.

Other Responses, Modifications of Therapy, and New Approaches

163.

Berlin, Sharon B. Better work with woman clients. *Social Work*, 21(6):492-497, 1976.

Berlin develops guidelines for social work intervention based on an understanding of the problems women are experiencing. Some interrelated problems are presented in terms of goals or therapeutic principles. A case history accompanies each presentation to illustrate the problem and how intervention can work. The first goal discussed is women's need to construct a new definition of self. Claiming that women have lost themselves in the process of trying to conform to an externally imposed image, Berlin recommends that counselors direct women to discover more about themselves and to act on this new awareness. This can be accomplished by self-assessment—for example, using journal keeping or some other technique that provides self-originating feedback and helps the woman realize that she has a clear individual identity. The second goal identified is the need for women to become more aware of their desires, alternatives, and power. Women must come to realize that they can exercise more personal freedom. Counselors can help in this process by pointing out areas in which alternative actions are possible and by instructing the women to make lists of possible alternatives to the way they act. Another goal presented is the need for women to consciously choose what response to make to existing situations based on their understanding of all the available alternatives. As a result of their socialization, many women find making conscious choices a very threatening activity because of the responsibility it entails. Attention is next given to the goal of women taking action to influence their own lives. Berlin believes that women must learn new skills for taking charge, since they previously have been denied this opportunity. Role rehearsals with a counselor and practice of alternative responses in daily life are suggested as a means of developing these skills. The need for women to communicate honestly and from a position of self-respect and self-centeredness is the fifth goal discussed. Berlin advises the counselor to encourage the woman to be selfish, to value herself sufficiently to insure that her own needs are met. The final goal identified is influence. The counselor's task is to help the woman realize that she must take charge of the therapeutic process and define the problems she wants to work on as well as find the courage to exert influence in her life and in her contacts with other people. Berlin concludes by stating that women feel bad because of the powerless position imposed upon them by their societal training rather than because of personal pathology. Counselors can help by encouraging women to value themselves and develop the necessary skills to function as fully independent adult human beings as well as by letting each woman know that she is not alone in her struggle.

164.

Brashear, Diane B., and Willis, Kathleen. Claiming our own: A model for women's growth. *Journal of Marriage and Family Counseling,* **2(3):251-258, 1976.**

The authors present a model for giving women an opportunity to exercise individual ownership and for helping them deal with issues of identity and change. In their observations of 250 women, the authors found that women want to be something of their own making—simply getting a job and fulfilling the male career orientation is not sufficient. The ownership model is based on the concept that control and ownership of their environment and personal life will give women the means to express their identities and develop their personal life styles. Gaining ownership is identified as beginning a process of independence training. To gain ownership, women must develop the ability to be assertive and resist the social pressures that deny women the right to claim things as their very own. The authors suggest that the list of possibilities for ownership most often includes the things society has taught women they cannot have. The issues of personal space, personal time, money, thoughts and feelings, and talents and hobbies are discussed in terms of how they are denied women, their importance for forming an independent identity, and how women can attempt to claim them. Ownership of one's own body is presented as one of the most basic issues in personal growth for women. The authors point out that socialization creates obstacles for women attempting to determine their own identities. Not only are traditional stereotypes reinforced, but socialization prevents girls from developing skills in dealing with the world and confidence in their own ability to form an independent identity. Women have not been prepared to gain their sense of personhood through ownership, and often their beginning attempts to claim things will be weak or misplaced. When a woman owns herself and can claim ownership of what she needs, she gains control of her own identity. The authors suggest that clinicians and educators substitute the expression "lack of ownership" for "lack of identity," for this will make a woman's problems become much more tangible. An ownership inventory can be taken, and then realistic ownership possibilities can be identified. After establishing realistic goals, the practitioner must examine the specific barriers that keep the woman from reaching her goals. When these barriers are identified, a plan can be developed to overcome them. The authors report that assertiveness training is especially useful when coupled with concepts of ownership. At the end of the process of achieving ownership, an evaluation of the outcome should be done. In that a woman's ownership claims will affect the lives of her significant others, the authors suggest that it may be necessary to work with them too. The authors conclude that personal ownership means being oneself and is a very individual process.

165.

Brien, Lois, and Sheldon, Cynthia. Gestalt therapy and women. In: Rawlings, Edna I., and Carter, Dianne K., eds. *Psychotherapy for Women: Treatment Toward Equality.* Springfield, Ill.: Charles C Thomas, Publisher, 1977. pp. 120-127.

In this article based on the authors' experience as Gestalt therapists, Gestalt therapy is presented as a nonsexist philosophy and approach to facilitating human growth. A short description of Gestalt therapy as formulated by Fritz and Laura Perls is provided. Most psychiatric symptoms are identified as coming from blockages to the individual's natural organismic flow of experiences and actions. People create these blockages in themselves by suppressing open expression, maintaining poor perceptual contact, or through actual muscular repression. Using various methods, Gestalt therapy works to unblock the individual's organismic flow. Its focus is on how one is acting rather than why; on active experience in the present; and how the individual is stopping organismic functioning. In becoming aware of how one is blocked, the individual becomes aware of alternatives and has greater choices for action. Gestalt therapy is regarded as applicable to all individuals without gender designations. Its phenomenological approach does not support the notion of sex roles. The authors note that women in this society rarely view themselves as whole creative persons. They are much less sure of what they want than men are and usually seek therapy with little awareness that they need anything more than symptom relief. The initial task of the Gestalt therapist is to help women get in touch with who they are and find out what they want from themselves and others. Presenting an example, the authors note that becoming clear about what one wants can be very risky for a woman, because her current relationships may be unable to supply her with what she discovers she wants. Unlike clinical psychology and psychiatry, Gestalt therapy is focused on finding the person's unique characteristics and determining what the person wants rather than on what is wrong with the person. Women are brought up to rely on and give their power to men, but a basic Gestalt tenet is self-responsibility. The low self-esteem that characterizes so many women is identified as related to their failure to take responsibility and tendency to relinquish power to others. Gestalt's work makes women aware of their conditioning. When women get in touch with their internal feelings and sensations, they cease to maintain roles that do not fit who they are despite their cultural introjects. Gestalt therapy also deals with the problem of competition. The competition that characterizes many women in their dealings with one another is identified as playing a "fitting game," which restricts the ability to experience, sense, and feel. The Gestalt process encourages experiencing and appreciating differences rather than competing with them. The authors conclude that the Gestalt approach helps women to enhance their self-esteem, discover their wants, take responsibility for themselves, and get out of the competitive mode and into loving supportive relationships with others.

166.

Fodor, Iris E. Sex role conflict and symptom formation in women: Can behavior therapy help? ***Psychotherapy: Theory, Research and Practice*****, 11(1):23-29, 1974.**

Fodor begins by citing Broverman et al. (1970) and Neulinger (1968) regarding the different standards mental health professionals maintain for healthy men and healthy women, and by discussing the dilemma that these incompatible standards create for women. She identifies the reported, considerably higher incidence of mental illness among women as possibly due to women's greater sex-role conflicts. Noting that the psychotherapy establishment has been severely criticized for its inability to deal with role conflict and social change, Fodor suggests that behavior therapy may provide the techniques for changing or eliminating old roles and learning new ones. Fodor notes that when she reviewed the case histories of her women clients over the past 5 years, she was impressed by how often role conflict was the basis of the problem, although it was not perceived as such at the time of therapy. Behavioral techniques had proved to be effective in dealing with the problems even when the source was not identified. She reviews some of the problems she has dealt with effectively—focusing particular attention in this article on achievement, phobias, depressions, sexual problems, and female delinquents- and discusses how they related to sex-role conflicts. Case history examples of how behavior therapy helped women to overcome achievement-related problems, phobias, and depressions are included. The overt symptoms related to the achievement issue generally appear as work blocks, phobias, or anxiety attacks; some patients exhibit neurosis centering around the "fear of success" (Horner, 1969) syndrome. In almost all the phobic cases treated, the basic underlying problem involved fears of separation from home and becoming independent. Identifying feelings of helplessness and dependency as common to depressed women, Fodor suggests several therapeutic approaches: (1) behavioral treatment which enables the women to maintain records of their depressed moods so that they can learn the relationship between these states and their expectations of reinforcements; (2) consciousness raising and contact with other women in similar situations; (3) assertiveness training; and (4) setting up realistic behavioral goals in a hierarchy. Fodor identifies fear of orgasm or avoidance of sex along with nonorgasmic symptoms as the most frequently seen sexual problems and notes the importance of stressing the complicated nature of the problem and its relationship to sex-role conflict, particularly the active-passive dimension. The female delinquent represents a special case of conflicts over the feminine role; she vascillates between open rebellion and stereotypic "feminine" behavior. Fodor suggests that if one is to do behavior therapy with female delinquents and help them integrate the role polarities they are struggling with, the concept of adaptive feminine behavior must be reconsidered. Noting that sex-role conflicts appear to be a problem common to most women and believing current research on female psychology and consciousness-raising efforts to be insufficient, Fodor suggests that behavior techniques can be helpful in teaching women to do something with their new insight. The author concludes by indicating that it is important to eliminate all sex-role stereotyping and that therapists need to examine their own values to be certain that they are not reinforcing stereotypes.

167.

Franks, Violet, and Burtle, Vasanti, eds. ***Women in Therapy: New Psychotherapies for a Changing Society.*** **New York: Brunner/Mazel, 1974. 441 pp.**

Psychotherapy for women has traditionally been carried out by men functioning from a male point of view. Because of this history, many feminists have concluded that therapy, as now practiced, does not take into account the special needs of women. Franks and Burtle, however, have chosen to explore this question further. The material presented in this volume, which was gathered from a group of experts in the field of therapy, examines women and their changing roles. Women's problems are identified, and what happens when they seek professional help is described. The editors suggest that drawing upon the ideas and experiences of the innovative therapists and thinkers represented in this book is a good way of becoming aware of the value psychotherapy can have for women. The book is intended to offer many paradigms for a better understanding between the sexes as well as a fuller realization of woman's growth and potential. Divided into six sections, the book opens with a section presenting "An Historical View," which contains the article "Changing Views of Women and Therapeutic Approaches: Some Historical Considerations" by Humphrey Osmond and the two editors. The second section, "Biological and Cultural Influences," includes the following contributions: "The Sex Hormones, The Central Nervous System and Affect Variability in Humans" by Judith Bardwick; "Cultural Values, Female Role Expectancies and Therapeutic Goals: Research and Interpretation"* by Anne Steinmann; and "The Psychotherapist and the Female Patient: Perceptions, Misperceptions and Change"* by Benjamin Fabrikant* "Four Approaches to Problematic Behaviors," the third section, consists of "Cognitive Therapy With Depressed Women"* by Aaron Beck and Ruth Greenberg; "The Phobic Syndrome in Women: Implications for Treatment"* by Iris G. Fodor; "Women and Alcoholism"* by Edith Gomberg; and "New

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*Abstract of article included in this bibliography.

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Viewpoints on the Female Homosexual"* by Bernard Riess. The following seven sections are included in the section entitled "Contemporary Psychotherapies": "Women in Behavior Therapy" by Arnold Lazarus;* "The Therapy of Women in the Light of Psychoanalytic Theory and the Emergence of a New View"* by Esther Menaker; "Women in Therapy—A Gestalt Therapist's View"* by Miriam Polster; "Anna O.—Patient or Therapist? An Eidetic View" by Akhter Ashen; "The Treatment of Sex and Love Problems in Women"* by Albert Ellis; "Creative Exits: Fight Therapy for Divorcees"* by George Bach; and "Consciousness-Raising Groups as Therapy for Women"* by Barbara Kirsh. The fifth section, "Therapy and Agencies," presents "Women in Institutions: Treatment in Prisons and Mental Hospitals"* by Ephraim Howard and Joyce Howard and "Psychotherapy with Women and Men of Lower Classes" by Iradj Siassi. The final section, "Overview: Conclusions and New Directions," is an article by Suzanne Keller, "The Female Role: Constants and Change."

168.

Fried, Edrita. Does woman's new self-concept call for new approaches in group psychotherapy? *International Journal of Group Psychotherapy*, 24(3):265-272, 1974.

In this article based on her own experience in leading therapy groups, Fried discusses how the new female self-concept that has emerged from the women's movement has affected the group therapy process. She reports that in recent years women have been seeking group therapy more actively than men because of a need to integrate their new concepts of femaleness into their own self-images. Women now realize their secondary roles in the work world have been culturally rather than anatomically determined. Thus, many women come to groups wanting help in identifying their talents and encouragement in pursuing new occupational goals. An example is given of how one group assisted a woman to be more successful in a new occupation. Despite changes in self-concept, many women still consider it inappropriate for a woman to actively pursue a partner. In Fried's groups the idea is presented that risk must be taken if love is to be achieved. Women's feelings of social or physical inferiority are dealt with in the group, and open discussion of their feelings about women by male group members often helps this process. Fried identifies a need to focus on the privilege of erotic and sexual initiative so women can develop this as part of their new selves. She also feels that if women are to be sexually responsive, they must become comfortable with taking an active part in the sex act. Group members are made aware of how much sexual repression still exists, and open discussion of sexual specifics is encouraged. Gradually, fears are discussed and group members often display physical affection for one another. Fried also points out that many women are joining groups because they want to become direct and nonmanipulative in their interactions. Interaction practiced in group sessions is perceived as encouraging straight forwardness. Women also join groups because they want new forms of friendships with other women. Often, the women become so involved in identifying with and caring for each other that they may form a subgroup within a coeducational therapy group. Fried suggests that the deep alliances formed between women in groups may be one of their most desirable therapeutic effects. She concludes that the emergence of a new self-concept for women has aided the traditional therapeutic process of raising women's self-esteem and reducing their anxiety as well as their narcissistic isolation.

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*Abstract of article included in this bibliography.

169.

Fromhart, Mike. On becoming a feminist-oriented male psychotherapist. *Voices*, 12(3):23-27, 1976.

Fromhart's purpose is to stimulate male therapists to reassess their thinking about women and develop innovative treatment strategies for their female clients. Writing as a male therapist who is sensitive to sexist and feminist issues, he identifies his struggle to be aware of and eliminate sexism in himself as an ongoing one. Practical tasks are recommended to male therapists to help them evaluate their own sexist attitudes—becoming acquainted with current feminist literature, joining a feminist organization that has open membership, initiating dialogue with women and getting more in touch with the feminist struggle, and attempting to critically examine their own relationships with women. Fromhart presents several therapeutic strategies he has developed and found effective in his feminist-oriented work with women. These are compatible with his belief that therapy, especially for women, must provide conditions for growth and change rather than simply adjustment to existing conditions. For severely depressed or phobic women, individual therapy with reinforcement for small positive changes may be necessary initially. He notes that action therapies, such as cognitive restructuring and behavioral rehearsal, have been vital to his therapy efforts. When women are free of severe symptoms and generally assertive, he strongly recommends a group therapy experience with other women. Fromhart sees this experience as a way of decreasing the possibility of the client's becoming dependent on her therapist and of helping the woman form a sense of identity and self-worth. The use of male and female co-therapists is also recommended so long as both therapists are careful not to fulfill stereotypical roles. Environmental support for the gains women make in therapy can be found in consciousness raising and by involvement of a male partner in the therapy. Fromhart believes however, that regardless of how the male partners respond, therapists have a responsibility to encourage women in their struggle for autonomy and role flexibility. He goes on to suggest that therapists-in-training should be required to examine their sexist attitudes and behaviors, and recommends the use of personal awareness exercises and other devices to resocialize students so that they will be better able to help their clients develop fully.

170.

Glatzer, Henriette T. Discussion. *International Journal of Group Psychotherapy*, 24(3):281-287, 1974.

In this discussion, Glatzer responds to articles on the impact of the women's liberation movement on group therapy by Mintz and Fried. Glatzer claims that the priorities of treatment come first and that the subject of women's liberation demands the same psychotherapeutic approach as any other subject. Freud is defended, despite his early work on the Oedipus complex and chauvinistic attitude toward women, on the basis of his later work on the phases of pre-Oedipal development. Glatzer views Mintz's examples of sex-role stereotyping by group therapists as reflecting antitherapeutic countertransference and suggests psychoanalytic rather than social bases for their occurrence. Great concern with women's liberation within the group situation is seen as a device to avoid anxieties having to do with intragroup and/or intrapsychic conflicts. Glatzer describes how she turned two separate discussions about political/social issues into valuable personal therapeutic work for the group members who brought up the topics. She suggests that when a woman's drive for equality is unhealthily consuming, it refects feelings of unresolved rivalry and of inadequacy toward the pre-Oedipal mother. Glatzer concludes that the need to work on various aspects of the women's movement as presented by

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Fried is not an adequate reason to join a psychotherapy group. She sees no need to modify the approach of group psychotherapists to deal with women's liberation so long as the therapist analyzes the problems that manifest themselves around this social problem.

171.

Holroyd, Jean. Psychotherapy and women's liberation. *The Counseling Psychologist*, 6(2):22-28, 1976.

Holroyd begins by briefly examining some of the background factors that have shaped information about women. She then reviews the literature on issues raised by the women's movement and how they are being addressed in current psychotherapy. Although there is still considerable confusion about female sexuality, Holroyd notes that women have changed their self-concept and want to take a more active role in initiating sexual contacts. That society's attitude toward women's sexual liberation remains ambivalent is reflected by women in therapy. Despite societal ambivalence, treatment of sexual dysfunction is being carried out in major treatment programs like that of Masters and Johnson, and feminist therapists are treating dysfunction by helping women to develop positive self-concepts and to see themselves as sexual equals. Holroyd reports that women seeking therapy today are critical of therapists with stereotypical attitudes about femininity; they "insist that their femininity be taken for granted because they *are* female." Radical therapy is identified as appealing most directly to women's dissatisfactions with their economic and familial roles—bringing awareness of the oppressive nature of women's traditional roles, allowing the expression of appropriate anger, and helping women move toward new orientations that offer fulfillment. The consciousness-raising group is considered a major contribution of the feminist movement. Although not defined as therapy, the consciousness-raising group is reported to bring about changes in women that can be viewed as therapeutic. Feminist therapy, that focuses on sexism that has retarded women's growth, is described as a combination of radical therapy philosophy with humanist therapy techniques and behaviorism. Holroyd suggests that women's neurotic problems can be viewed as the consequents of cultural conflict and constraints. She notes that problems specific to women—agoraphobia, passive-dependence, underachievement, and depression—have received special attention in the literature and reports briefly on the techniques used to treat these problems. In conclusion, Holroyd presents six principles—useful regardless of the therapist's orientation—for dealing with the impact of sex-role stereotyping and sexism on clients: (1) the client's self-report should be respected above all; (2) the client should be related to as an individual valued in her own right; (3) the therapist should share her/his attitudes about woman's role; (4) there should be recognition that the society's ambivalence about sexuality and woman's role may cause a client much confusion and grief; (5) women's groups are valuable in allowing identification with other women who see themselves as competent and in providing mutual support while women are undergoing changes; and (6) therapy should be supplemented with specific training (e.g., assertiveness) to counteract deficiencies in socialization skills due to sex-role stereotyping.

172.

Hutchinson, Sally A. Women's lib and psychotherapy. *Journal of Psychiatric Nursing and Mental Health Services,* 13(6):20-22, 1975.

A psychiatric nurse therapist discusses the theory of transactional analysis and its use with women patients. Describing transactional analysis as a pragmatic and effective method of diagnosing, analyzing, and solving problems, she points out its obvious parallels with the message of the women's movement. Reference is made to Eric Berne who identified set patterns of feelings and their related behaviors, which he defined as ego states—Parent, Adult, and Child. These ego states are described, and the Adult ego state is depicted as one that objectively appraises reality and, consequently, must often recognize and balance the forces of the Parent and Child ego states. According to Hutchinson, a "healthy" individual has her "Adult" in "executive position," and the Adult determines what behaviors—Child, Parent, or Adult—are appropriate in certain situations. If a woman is experiencing problems, her Adult needs to be activated so that she can make self-beneficial decisions. Discussing Claude Steiner's description of the socialization of women, the author concludes that the female profile presumes qualities of passivity, compliance, nurturance, and perceptiveness about others—a selfless docile human being. One of her therapeutic goals is to overcome this image by working with the woman client to strengthen her Adult. Since the Adult needs to be both exercised and used in order to be more efficient and effective, the client is first asked to make a contract that identifies what she wants to gain from therapy and how she wants to change her behavior. An example is provided of a woman's realization, as a result of therapy, that she was devoting an inordinate and unnecessary amount of time to caring for her family. The author views herself as a resource person and a facilitator. She suggests alternative behaviors to the woman client and helps her to accept responsibility for her actions. The author elaborates on the process a woman must undergo in order to appreciate what different kinds of things will bring her happiness. When a woman begins to recognize a problem and to feel that she has choices about her life, there can be a breakthrough in psychotherapy. The author concludes that her experiences with women have made her increasingly aware of the culture and how it affects life patterns. Her goal is to offer patients and students workable alternatives to potentially oppressive lives.

173.

Jones, Moyra J.D. Project alternative: The road way from isolation. *The Canadian Nurse*, 71(2):25-27, 1975.

Project Alternative, the focus of this article, is a joint hospital-community therapeutic group developed by occupational therapists. Its purpose is to help women isolated by longstanding psychiatric problems move into community activities. A portrait is presented of a typical member of the project, a frightened middle class housewife who has been in and out of psychiatric facilities. The social club is used as therapy, because a patient's social adjustment is considered to be a vital component of rehabilitation. Jones points out that concrete skills and attitudes must be learned before patients can participate in community life. She discusses why therapeutic social clubs proved unsuccessful in the past and presents the theoretical base of Project Alternative. The project was designed to help women with a history of depression. The women involved, all at high risk for hospitalization, were experiencing difficulty interacting with others. They complained of isolation, fear, and hopelessness. The project was begun in cooperation with a local YW-YMCA whose traditional programs had had a high rate of failure with these women. Personnel with a genuine regard and concern for the women as well as an ability to evoke trust were identified as vital to the new program's success. No more than 10 women were in each group, meeting twice weekly for 10 weeks. The project functioned primarily as a client-centered therapy. Flexibility was emphasized so that clients could develop the situation to fill their own needs. The many activities offered are itemized. Great care was given to preparing the facility, transportation arrangements, explanation of the day's activities, and continuity in the presence of significant figures. The patients, who knew almost nothing of their community resources, were very fearful initially. As the project proceeded, positive attitudes came to predominate as each success was experienced. Patients began to form new patterns of behavior. They came increasingly to communicate with each other and to accept responsibility for how their time was spent. Some members began to participate in activities outside their homes, and some made friends for the first time. Project Alternative offered its participants a health model that could serve as an alternative to continuing hospital dependency and isolation in their homes.

174.

Kaschak, Ellyn. Sociotherapy: An ecological model for therapy with women. *Psychotherapy: Theory, Research and Practice,* 13(1):61-63, 1976.

Kaschak identifies a growing awareness of the discrepancy between psychological theories and the actual experiences of women. Only when psychological theories accurately describe woman's cultural experience will therapists be able to "cure" what the author identifies as this society's most pervasive psychological problems—women's impotence and men's frigidity. Sociotherapy has been developed as an alternative to traditional psychotherapy. By helping women see their problems as existing in a broader social context, it incourages them to recognize oppression as a reality and to become involved in action that will lead to change. Sociotherapy focuses on the traditional divisions between men's and women's labor and sex roles, with the goal of reclaiming and reintegrating those parts of the self that society has made the individual deny. The "double bind" concept (Bateson et al., 1956) is presented as vital to sociotherapy and to understanding the role of women in this society. In double binding, a message is sent that one can only respond to by denying the validity of one's own personal experience. In essence there is no correct choice. A person who depends on the sender of the double bind messages for survival will learn to respond within the confines of their paradox but comes to feel something is wrong because nothing "makes sense." Examples are given to show how women have been caught in the double bind. The author suggests that women lose by winning and win by losing and that the only way to escape from this trap is by "leaving the field" of the double bind and recognizing the absurdity of the choices made available to them. Only recently, with the advent of the women's movement and the realization that they need not be dependent, have women had any escape route. Women have begun to validate each other's experience and realize something is wrong with a society that offers women no "real" choice. Women can only begin to realize who they are when they escape from who they are not and begin to reintegrate their experience. According to the author, it is only through this reintegration that a new psychology of women can be developed. Sociotherapy involves the active sharing by the therapist and group members of their own experiences as women in this society. The therapist is identified as a functioning member of the group who has an important skill needed for the group process. "Leaving the field" of the double bind and actively creating alternatives are identified as the vital parts in the process of sociotherapy. The therapist and clients join forces to create "broad ecological change within the entire social context." The goal of sociotherapy is for women to become fully functioning human beings.

175.

Kenworthy, Joy Anne; Koufacos, Corinne; and Sherman, Julia. Women and therapy: A survey on internship programs. *Psychology of Women Quarterly*, 1(2):125-137, 1976.

This survey was undertaken to learn how internship programs were responding to the discrepancy between psychotherapy's ethical ideal and the reality of therapeutic practice with women. In March 1975 a questionnaire about training practices was mailed to all known clinical or counseling internship programs in the United States. Fifty-five percent of all American Psychological Association approved internship programs responded, representing 264 female and 539 male interns. The first group of results provides a description of the respondents and some basic information regarding the program. The second group of results is in response to questions about provisions for training to work with women clients. Special training for work with women was reported by 29.8 percent of the internship programs, and 23.4 percent mentioned workshops and/or groups directed toward increasing awareness of men's and women's issues. Responses to specific questions about provisions for training are discussed in some detail. A third category of results deals with projects related to women's issues in which interns participate. Interns had worked on projects designed especially to meet the needs of women in 39.4 percent of the programs over the last 3 years. These programs were a part of the formal internship at 20 percent of the institutions. No prior training or experience in working with women was required for admission to 28.6 percent of the internship programs; 53.8 percent considered an awareness of women's issues to be important. Of the programs responding 33 percent had made some effort to alleviate discrimination against women interns. A need to change their current programs to better develop the skills of interns in working with women was identified by 20.2 percent of the respondents, and the authors consider this a hopeful sign. To questions concerning what qualities would qualify or disqualify therapists to work with women, most respondents answered with general characteristics like sensitivity and and empathy. Only 17.9 percent of the women and 12.8 percent of the men specifically stated that evidence of sex bias made therapists unqualified to work with women. The reaction to whether there should be certification/licensing for work with women was overwhelmingly negative (93.7 percent). The authors interpret the data as suggesting that only a minority of internship programs deal with issues of sex bias and sex-role stereotyping on any systematic basis. Supervision is mentioned most frequently as the method for dealing with these issues, and the authors discuss this as a simplistic and not necessarily effective way of approaching them. In concluding, the authors provide several specific suggestions of what programs can do to incorporate information about sex bias and stereotyping into their learning process.

176.

Knefelkamp, L. Lee; Widick, Carole C.; and Stroad, Barbara. Cognitive-developmental theory: A guide to counseling women. *The Counseling Psychologist*, 6(2):15-19, 1976.

This article proposes cognitive-developmental theory as a valuable conceptual framework for counseling women. Cognitive-developmental theory is described by presentation of its three central ideas—structural organization, developmental sequence, and interactionism. A person's structural organization is determined by how she perceives herself and the outside world. Developmental sequence is identified as a progression to a more complex and integrated structural organization that occurs because of interactionism, or dissonance, created by the interaction between a person and the environment. A list is presented of five patterns of the developmental sequence based on the separate work of Kohlberg (1970), Perry (1970), and Loevinger and Wessler (1970). Perry's specific cognitive-developmental theory is then presented to illustrate how it can function as a framework for understanding women clients and their views of "women's issues" and themselves. Perry's model consists of nine developmental steps in thinking, each one more complex than the one before. These nine steps will move a client from a simplistic view of herself and her role in society to a more pluralistic view. The nine steps are divided into three major phases—dualism, relativism, and commitment to relativism—and these are fully described. The authors identify the purpose of counseling as fostering movement through this developmental hierarchy. They consider the concept of nine stages of development as helpful in understanding where a client is cognitively and in assisting her to move on to a more complex world view and a better developed sense of self. According to the authors, counseling emphasis should be on cognitive process rather than on content, and interaction must be conducted on a stage by stage level and never more than one stage above the client's present stage if development is to continue. "Support and challenge" is the central intervention concept of cognitive-developmental counseling with the client receiving sufficient support as she is challenged to grow, to progress to the next developmental stage. Counselors need to undergo this treatment process in their own training if they are to guide their clients along this route. They also require a thorough understanding of alternative perspectives related to counseling women and women's issues as well as an understanding of their own views on these subjects. The authors suggest that a counselor should have a theoretical framework from which to counsel women, indicating that too often this is replaced by a political stance. They conclude that the counseling profession might benefit from exploring and developing counseling implications on the basis of cognitive-developmental theory.

177.

Kronsky, Betty J. Feminism and psychotherapy. ***Journal of Contemporary Psychotherapy*, 3(2):89-98, 1973.**

Acknowledging that the women's liberation movement has had a personal impact on therapists, Kronsky reports that there have been few efforts in the literature to deal with the technical innovations that could emerge from the feminist perspective. In response to this lack, she suggests a reformulation of technique used in the therapeutic management of assertiveness in women patients. Disregarding those aspects of Freudian theory influenced by the patriarchal myths of his culture (such as the view of women as biologically deprived creatures), she identifies an element of truth in Freud's theory that assertive women have made masculine identifications. This identification has sociological and cultural rather than biological causes. Women who identify with or envy men do so because they recognize the socially and politically advantageous position of men in this society. Reference is made to Clara Thompson's view that the lack of a penis may become both a symbol of, and a rationalization for, the perceived disadvantages of being a female. On the basis of her clinical experience, Kronsky suggests that such symbolic "penis-envy" is eliminated when a woman is helped to accept her own sexuality and to become assertive. Women often come to therapy blaming themselves for their anger at their limited roles, ashamed of their feelings of resentment, and doubting whether they are feminine enough and whether they have the right kinds of feelings and the right kinds of orgasms. These women are so sensitive to the opinion of others that they will usually interpret most of the therapist's comments as the negative self-valuations they fear. Interpretations or even "mirrorings" of their negative attitudes can convey implicit normative messages to these women, making them feel there is something unhealthy about their negative attitudes. The author suggests that these women need a permissive atmosphere in therapy, one which allows them to express their feelings, to deal with their strivings for assertiveness, and to focus on the early partial identifications they had made with active men and women and later discarded. She recommends her approach of taking the following simple precautions when working with the assertive strivings of women patients: avoid interpretations which focus on anger or competitiveness toward men; communicate acceptance of the woman's strivings to be more assertive; and do not give particular attention to the attitudes of "penis-envy," hatred of men, and masculine competitiveness. In the author's opinion, a feminist therapist will regard partial identifications with father figures as normal and healthy in this society, will focus attention on helping the woman to improve her self-concept and develop her assertiveness, will avoid interpretations that would serve to reinforce the woman's tendencies to concentrate on her relations with men and to perceive herself as a sex object, will contradict the views of other therapists if the situation warrants, and will be sensitively aware of what it means subjectively to be a woman in this male-dominated society. In concluding, she notes that for all these objectives to be achieved, the feminist-oriented therapist will have to be a woman. Three case histories are presented of women who were helped to become more assertive.

178.

Lazarus, Arnold A. Women in behavior therapy. In: Franks, Violet, and Burtle, Vasanti, eds. ***Women in Therapy: New Psychotherapies for a Changing Society.*** **New York: Brunner/Mazel, 1974. pp. 217-229.**

Lazarus asserts that sex differences play no part in behavior theory; behavior therapists have been training women as well as men to be self-sufficient and assertive for years. Behavior therapy makes the value judgment that assertive behavior is preferable to submissive behavior for both women and men. However, as sex stereotypes predominate in this culture, a therapist must deal with the effect of these stereotypes on individuals. Lazarus identifies the ways in which women can be helped rather than hindered by male therapists. A first consideration, however, is "expectancy fulfillment"; it is better for a woman to be in therapy with someone she feels optimistic about—regardless of the therapist's sex. A definite advantage of a male therapist for many women is that he often can provide a different male model than the patient has been use to, thereby opening new options. To assess the role of sexual attraction in treatment of women by a male therapist, Lazarus surveyed his patients; he found that because of the goal-oriented and problem-solving nature of behavior therapy, sexual attraction was actually an unimportant factor in therapy outcome. Also, a male therapist is usually needed to intervene with a male partner who is perpetuating a relationship in which a woman depends on him for her own status and self-esteem. Lazarus discusses the benefits of enlisting the assistance of a female co-therapist when involved in teaching women and men how to relate to each other as poeple. In situations where a crucial element of change seems to require a female rather than a male role model, he refers a female client to a female therapist. Lazarus points out that the objective of behavior therapy is to aid people in coping with the external world so they can achieve a sense of their own mastery and fulfillment. The patient's sex is only important in understanding the way he or she has been treated by society; the desired outcome of the therapy remains the same.

179.

Lewis, Judith A. Counselors and women: Finding each other. ***Personnel and Guidance Journal,*** **51(2):147-150, 1972.**

This article is essentially a plea for professional counselors to be responsive to the needs of women. Lewis first describes the excitement women experience as they share and learn in consciousness-raising groups. They are gaining strength and knowledge in these groups—an outcome that should be the counselor's dream. Women are bypassing the normal helping institutions because they fear being counseled to adjust to secondary roles and being forced to ignore the commonality of all women's experiences. Lewis points out that counselors could help if they came to share the dreams women have for themselves. Indeed, counselors have a unique opportunity to bring the idea of consciousness raising to women who have never previously considered it. The concept of the rap group could be included in all situations where women are counseled. In public schools these groups would give girls a chance to grow from a base of understanding and mutual support that would allow them to examine all the choices available to human beings without constriction from sex-role stereotypes. College women could be helped to deal more realistically with the problems facing them. The author also suggests that within social service agencies the women seeking help could form a coalition based on an understanding of the ties that bind them together. This could be the first step to finding a way to change rather than cope with their environment. Counselors could also work to ensure that their colleagues were functioning as "oracles of liberation rather than sources of limitation." Lewis notes that counselors must initially focus on themselves before they can make a real impact on society by using their skills to raise consciousness. They must work through the often painful process of becoming free and strong and must develop an acute awareness of the inequities of society. Lewis concludes by suggesting that the consciousness-raising movement provides the right vehicle for this growing process but that counselors must first find the motivation to grow within themselves.

180.

Mackeen, Beverly A., and Herman, Al. Effects of group counseling on self-esteem. ***Journal of Counseling Psychology,*** **21(3):210-214, 1974.**

Three different groups of women were involved in a counseling program designed to improve self-concept. Secondary objectives of the counseling were to reduce anxiety, depression, and hostility. Group discussions were oriented toward topics that would improve self-knowledge and develop skills, such as goal setting and decision making. Small group sessions were supplemented with large group meetings where speakers provided personal or vocational information. The three groups of women differed in social class and in marital status. One group of 24 women was recruited through newspaper advertisements. Since each woman was able to pay $40 to participate in 40 hours of counseling over a 9-week period, the researchers assumed that these women were middle class. All but two were married and living with their husbands. The second group of nine members met for 126 hours. Referred by social workers in a rural area, they had been receiving public assistance for over 3 months. Two of the members were single but raising children and the rest were either separated, widowed, or divorced. The third group of 15 members met for 108 hours. They were referred by social workers from an urban area and had been receiving public assistance for less than 3 months; one member of this group was single, two were living with their husbands, and the remainder were separated from their husbands. The Tennessee Self-Concept Scale and the multiple Affect Adjective Checklist were used to obtain pretest and posttest scores for self-concept, anxiety, depression, and hostility. A multivariate analysis of covariance was carried out to test the differences among the three groups on these measures. The multivariate test was significant at the .02 level. Univariate tests revealed that self-esteem differences accounted for the significance and that other dependent variables did not account for significant amounts of variance. The women who had been receiving public assistance for over 3 months and who lived in the rural area benefited the most from group counseling. The authors conclude that the counseling experience was most useful to women who had no distracting crises to deal with, since their marital and financial status was relatively stable. They stress the need to ensure that clients are ready for certain types of group experience.

181.

Polster, Miriam. Women in therapy—A gestalt therapist's view. In: Franks, Violet, and Burtle, Vasanti, eds. *Women in Therapy: New Psychotherapies for a Changing Society.* New York: Brunner/Mazel, 1974. pp. 247-262.

Polster identifies a double thread running through the stories of her women patients: they feel trapped in a routine that keeps them busy but fails to satisfy, and they do not feel involved in making decisions about their own lives. She discusses the socialization process, which teaches girls to distrust their own experience and the knowledge it offers, and to take on instead the values and precepts of the adults around them. Polster contends that the imprint of the joys of the firsthand experience of early childhood lies beneath the socialized woman who becomes frozen with fatigue and ambivalence by the internal contradictions this memory creates. If women stay out of touch with that part of themselves that fails to conform to social expectations, they will be unable to take the action that is necessary for shaping their own lives. In gestalt therapy the focus is on the individual's responsibility for shaping her own life and involving herself, even in a hostile environment, in ways that will be nourishing and rewarding. This requires great energy and ingenuity that can only come from awareness and use of this awareness as a basis for action. When awareness is unimpeded, action will come forth naturally. Polster states that making changes is frightening to many women because they are afraid to reawaken aspects of themselves that are unpredictable and that may lead to consequences they will find unacceptable. Throughout the article, case histories are presented to illustrate how gestalt therapy has helped women overcome fear of awareness and the action it demands. A woman's fear comes, in part, from the judgments and values she has assumed from other people and is uneasy about questioning. Often she projects her unwillingness to change outside herself and decides she can have no effect on the world. To keep from having to make changes, she maintains an equilibrium in which she uses just enough sensitivity to feel her unhappiness but not enough to determine what to do about it. Women also use retroflection to avoid acting against their situations. They direct their disapproval of something or someone back onto themselves in a blanket self-condemnation. Additionally, women avoid action by making their goals too grand to ever start on them. Polster notes that growing up female in this society would cripple or deform all but the most exceptional. Women who are disdainful of the unhealthy behaviors and rewards established by society and women who outwardly adhere to traditional roles both pay a heavy price. Polster sees being a woman as very valuable in her work with women patients. Clients are more open in sharing experiences they know the therapist has had as a woman, and she provides personification of another way of being a woman. Polster concludes that good women and good men possess exactly the same human qualities, all of which are needed to create one's own life.

182.

Pyke, S.W. Counselling and the feminist. ***The Ontario Psychologist,*** **6(1):45-48, 1974.**

This article describes some of the difficulties encountered by the feminist that may lead her to seek counseling. After publicly verbalizing her views, the feminist may find herself a victim of the "standard bearer syndrome." People may pigeonhole her, and her interactions may become circumscribed. The unpleasant experience of feeling stereotyped may cause her to withdraw from interactions, only to develop feelings of isolation and alienation. Ethical conflicts may also create problems. If the feminist protests everytime she perceives an inequity, she may alienate people. Yet, if she compromises her principles and lets things go, she will feel guilty. The feminist may also find herself having difficulty with male authority figures, especially in academic settings where sexual overtones often pervade these relationships. Although annoyed by the way she is treated, the feminist cannot afford to offend those in control. Low self-esteem is a problem feminists share with women who have not had their consciousness raised. Moreover, some feminists set impossibly high standards for themselves. Loneliness is another problem feminists often face. As members of a minority group, they are isolated and may have difficulty relating to both men and women. They sometimes seek counseling to establish friendships. Problems in learning to be assertive rather than diffident may also cause feminists to seek counseling. The problems feminism creates in a woman's marital or cohabitation relationship are also identified as reasons for seeking counseling. The author concludes that to be most effective, counselors must be sympathetically aware of the unique strains and stresses feminists experience.

183.

Rawlings, Edna I., and Carter, Dianne K., eds. ***Psychotherapy for Women: Treatment Toward Equality.*** **Springfield, Ill.: Charles C Thomas, Publisher, 1977. 477 pp.**

This book includes articles with a feminist perspective and is intended as a guide to psychotherapeutic treatment that encourages women to develop to their full potential. It evolved from Rawlings' and Carter's belief that the sexist attitudes and beliefs that characterize many therapists result in therapy that is more harmful than beneficial. After examining sexism in the theories and practices of psychotherapists, they provide concepts and procedures which have proved useful in the process of helping women liberate themselves. Focus in the first section is on the importance therapists' values have for the treatment of women. Two chapters by Rawlings and Carter* examine how therapists' values about women are imposed on female clients during therapy. The chapters of the second section, also written by the editors,* distinguish feminist from nonsexist psychotherapy and provide comparative analyses of two case histories using sexist and feminist perspectives. In the third section Natalie Shainess* criticizes the psychoanalytic treatment that fails to help women move toward autonomy and self-assertiveness; Lois Brien and Cynthia Sheldon* describe gestalt therapy approaches that help women develop to their full potential; and Robert Seidenberg criticizes both the practice of marriage counseling and the institution of marriage while defending the structure of psychoanalysis. The fourth section deals with assertiveness training for women and includes two chapters by Jakubowski, "Assertive Behavior and Clinical Problems of Women"* and "Self-Assertion Training Procedures for Women."* Then, career counseling is presented as therapy that can help free women from their economic dependence. Lenore Harmon* offers an original theoretical conception of the occupational position of women; Cindy Rice Dewey* presents the vocational counseling technique she developed; and Theodora Wells* provides a guide to doing therapy with professional women. The sixth section is devoted to psychotherapy for lesbians and is written by two therapists who are lesbians themselves, Josette Escamilla-Mondanara* and Barbara Sang.* The editors indicate that the intention of this section is to raise the consciousness of the "straight" community. The chapters in the seventh section are concerned with the ways in which feminist ideology is proving therapeutic for women. Anica Mander discusses the concept of "Feminism as Therapy"** and Annette Brodsky** presents feminism's therapeutic efforts in consciousness-raising groups. Marie Guzell* writes of the changes that occur in women as the result of women's studies courses. A feminist bibliography developed by Jane Sanders and Dorothy Cox is also included. In the eighth section radical feminist therapists Ardelle Poletti Schultz** and Hogie Wyckoff* challenge the value of the treatment provided by the established mental health community and offer alternative treatments. The two chapters in section nine, one by Harold Adams and Leona Durham and the other by Norma Gluckstern* discuss the concept that participation in activism to achieve feminist goals can be therapeutic by creating beneficial personal changes in the women involved. The tenth section is an epilogue in which the editors examine the role mental health professionals play in maintaining the status quo for women and investigate how therapists can participate in social change to create a more humanistic and egalitarian society.

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*Abstract from this source included in bibliography.

**Abstract on same topic by author but from another source included in bibliography.

184.

Redfern, Margaret; Klass, Shirley B.; and Coleman, Kaye M. A housewives' group in a university setting. *Social Work*, **21(6):527-528, 1976.**

The authors briefly report on a program established at the University of Utah which uses group work methods in an educational setting to deal with the everyday problems of housewives. A social work leader-instructor offers a class, entitled "Three to Get Ready," which includes components of group work and casework services. The class meets 2 hours weekly for 10 weeks and has the following goals: (1) to offer students an opportunity for self-assessment through a combination of psychological testing and written assignments, and (2) to disseminate information on opportunities for careers, volunteer work, and further education. The class is divided into small groups to stimulate interaction and discussion among members. Social work graduate students lead the groups, which also become a vehicle for support, value clarification, and consciousness raising. Individual counseling is available upon request, and many students use this additional service. A majority of the class members are middle class, married mothers between the ages of 20 and 70. The long-range effects of the program are still being studied, but preliminary results indicate that the class promotes a positive self-concept. The authors report that it is now possible to raise feminist issues much more openly in the class than in the past. Presently, some sessions are devoted to discussions of role formation through the socialization process and to an examination of the basics of assertiveness training. The educational setting provides a socially acceptable way for women to be involved in a cautious exploration of their dissatisfactions with life and offers opportunities for growth and change. The authors conclude that an educational course such as "Three to Get Ready" with its emphasis on self-identity and assessment can be an exiciting and creative way to meet the needs of clients who seek help in preventing their emotional crises from becoming major debilitations.

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*Abstract from this source included in bibliography.

**Abstract on same topic by author but from another source included in bibliography.

185.

Shainess, Natalie. Treatment of crises in the lives of women: Object loss and identity threat. *American Journal of Psychotherapy*, **31(2):227-237, 1977.**

Shainess suggests that crises in the lives of women will be increasing because of the rapidity of change in our society and the accompanying disappearance of values and ethical commitments. She points out that crisis treatment is very demanding; no formulas apply and routine therapeutic efforts are inadequate. Each case demands quick diagnostic evaluation followed by a decision about what the primary emotional stress is, how it came about, what individuals are involved, what resources the woman has, and what can be done both quickly and on a more gradual basis. Shainess lists questions about the course of treatment that arise after a diagnosis has been made. Considering the types of crises that presented themselves in her practice over a period of a year or two, she notes that in terms of developmental damage and dynamics the crises could all be classified into two basic categories—fragility in identity and self-esteem or surviving object loss. Shainess discusses some of the emotional manifestations of crisis and indicates that a sense of powerlessness often prevails. A list of 14 types of events that have caused painful emergent problems in women is presented. These include both actions (e.g., suicide and suicidal equivalents) and reactions (e.g., reactions to abandonment, infidelity, or the crisis of old age). These crises are then recategorized and explained in terms of inner experiences. They are defined as existential crises, sudden object loss, sudden loss of self-esteem, damage to the body or body image, depressions of unknown etiology, threats from unexpected events that elicit paranoid conversion, and positive changes in the individual. Shainess provides short case illustrations of women experiencing crises within these categories along with outlines of the flexible treatment approaches she used in each case. Other crises that were dealt with in her practice are commented on very briefly. She concludes by evaluating the case of Lady

Macbeth. This fictional character is said to illustrate the fact that crises have their inception in early developmental problems which emerge in association with stressful, often self-created events.

186.

Smee, Patricia. Self-modification for women. *Corrective and Social Psychiatry and Journal of Behavior Technology Methods and Therapy*, **22(3):14-15, 1976.**

The use of self-modification to assist women in reevaluating their traditional sex role and learning new behaviors is briefly reviewed. Smee indicates that the roots of self-modification are in social learning theory, which assumes behavior is a function of environment and that behavior is learned. Consequently, she considers self-modification the appropriate treatment method for American women, whose problems reside in their environment and cultural training rather than in their intrapsychic dynamics. The negative aspects of culturally defined feminine traits and the usefulness of self-modification in altering these traits are discussed. Self-modification's systematic use of learning principles is essential in altering learning, and it increases a woman's sense of herself as an active human being who can control her own behavior and influence her environment. Smee briefly describes an eight-session group program that trains women to use self-directed behavior modification. This kind of behavior modification, she suggests, can be used in place of consciousness raising, because it offers women a systematic method for learning to change specific sex-role behaviors while giving them the same support and sharing that typifies consciousness-raising groups. It is also valuable for women who have already had their consciousness raised and subsequently choose to make systematic changes in their behavior and environment. Finally, group self-modification is regarded as useful in the treatment of women with moderate behavior disorders who are seeking therapy rather than consciousness raising.

187.

Steinmann, Anne. Cultural values, female role expectancies and therapeutic goals: Research and interpretation. In: Franks, Violet, and Burtle, Vasanti, eds. *Women in Therapy: New Psychotherapies for a Changing Society.* **New York: Brunner/Mazel, 1974. pp. 51-82.**

In this chapter Steinmann describes her research of female cultural values, role perceptions, and expectancies in general; provides data about men's attitudes on these matters; and discusses the implications of her research for therapeutic goals. Conducted over a 20-year period, the research is based on the assumption that although technological advances have freed women from their traditional roles, traditional values stand in the way of women's self-fulfillment, and, consequently, conflict is created. Empirical data were collected on the following two questions: (1) How do women view themselves—as they are, would like to be, and think men want them to be? (2) How do men see their ideal woman? Steinmann hypothesized that the effort to combine self-realization with the traditional nurturant role would result in conflict between the activity and independence women desire and the passivity and dependency men want them to exhibit. She further predicted that men would verbalize a desired level of activity for women that did not differ significantly from that indicated by women themselves. Steinmann presents a profile of the approximately 14,000 women and 7,000 men included in this cross-cultural study. The instrument used, the MAFERR Inventory of Feminine Values, is described. The results of testing were remarkably consistent, with the vast majority of women perceiving themselves as striking a balance between self and family orientations. They portrayed their ideal woman as slightly more family oriented but still essentially balanced and indicated that they felt men wanted women to be passive and strongly family oriented. Men who matched the female sample as much as possible were given the same inventory. Their ideal woman was balanced between family and self-orientation, like the women's ideal. A program of research was undertaken to determine which of four possible modes for interpretation of the data was most accurate. Results revealed that both men and women thought they were telling the truth and that a serious lack of communication exists between the sexes. Steinmann extensively discusses the greatly different responses of a sample of feminist women in the field of psychology. They were not at all interested in traditional role orientation, and their self-images were in extreme conflict with their views of how men wanted them to be. A group of male psychologists given the inventory showed the discrepancies to be similar to those of most men and women in the society. Contending that results support her two original hypotheses, Steinmann suggests that the discrepancies between the role concepts of men and women indicate the need for therapeutic goals that will help men and women examine their own motives and goals and break down the barriers to communication between them. She maintains that the MAFERR Inventory of Feminine Values and a similar inventory for men, Inventory of Masculine Values, can be valuable tools for identifying conflict and checking therapeutic progress. Two case studies are presented to illustrate the application of these inventories in individual and couple therapy. Addressing the issue of therapist bias, Steinmann asserts that only therapists who have explored their own attitudes about women's roles can encourage women to develop the strength to overcome sex-role conflict.

188.

Wesley, Carol. The women's movement and psychotherapy. *Social Work*, 20(2):120-124, 1975.

Wesley discusses the traditional view of femininity, learning theory, and the implications of these ideologies for the client-therapist relationship. She then recommends alternatives to the traditional models of therapeutic intervention. Freudian and neo-Freudian concepts of woman as an inferior being whose destiny is controlled by her anatomy, and whose "natural" role is as a passive nurturer are contrasted with learning, or modeling, theory. According to learning theory, which posits that all behavior is learned, the child learns male and female stereotypes from the people around her. Chesler's theory of an association between marriage and therapy, both socially approved institutions for women that operate to maintain social control, is cited at length. Wesley also addresses standards of normality, citing the findings of Fabrikant and of Broverman et al. that a double standard of normality exists in the therapeutic community. "Normal" male characteristics are generally valued positively by the culture, whereas "normal" feminine characteristics are regarded negatively. Fabrikant does indicate that this pattern may be changing with the influx of less traditional therapists. It is suggested that therapists' notions about women may be one cause of the higher incidence of mental illness in women and that therapists who share society's sex-role stereotypes may actually be antitherapeutic, serving only to perpetuate their clients' self-contempt. Consciousness-raising groups are presented as an alternative to traditional therapy. Their central idea is that the individual, social structure, and culture are interrelated and that explanations for individual problems can be found within the social context. The classical stages of a consciousness-raising group's development are reviewed and positive effects noted. Areas of improvement include self-image, self-acceptance, sense of self-worth, image of women in general. Independence, confidence, and ambitions are also sometimes enhanced. Behavior therapy is presented as another approach based on the principle that men and women's concepts of masculine and feminine are the result of conditioning and that women can be helped to become more assertive and self-sufficient through behavioral techniques. The effects of the women's movement on therapy suggest two implications for social work practice: the need to train therapists to be effective in helping women achieve their full human potential; and the need for therapists to be more aware of their own conditioning and biases. Wesley asserts that therapists must come to recognize their dual responsibility—to help the system change so that the newly competent woman will be accepted within it and to help their women clients assert themselves in an oppressive system.

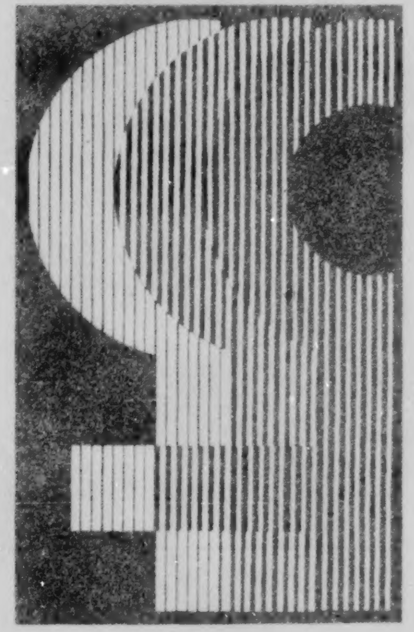
189.

Wyckoff, Hogie. Radical psychiatry for women. In: Rawlings, Edna I., and Carter, Dianne K. ***Psychotherapy for Women: Treatment Toward Equality.*** **Springfield, Ill.: Charles C Thomas, Publishers, 1977. pp. 370-391.**

This chapter begins by establishing radical psychiatry's political perspective. Radical psychiatrists are said to view themselves as community organizers who teach problem-solving skills and political awareness. They believe that because of psychiatry's political nature, men cannot help women to free themselves at this time and that the troubles of women result from their oppression. Radical psychiatry recommends social solutions achieved in group settings. Alienation is identified as a result of oppression, and the alienation that is felt by most women is discussed. A progression of three radical therapy equations is presented, and an explanation is given of how they apply to women. According to these equations, women must come to see their oppression for what it is. Then, working with others, they can achieve liberation. A structural analysis of ego states, taken from Berne's transactional analysis, forms the basis for much of this chapter. A diagram is provided to illustrate, in terms of ego states, why women feel resentment when men continually tell them what to do. The concept of banal scripting (Steiner) — how women and men are socialized to develop parts of their personalities while oppressing others — is presented. The ego development of men and women under banal sex-role scripting is illustrated in two separate diagrams. Men and women are mystified into believing they go together, when, in actuality, scripting causes them to be puzzles to one another. A diagram shows the possible transactions between banally scripted men and women. In that effective communication is impossible, so are intimate, satisfying relationships. Another diagram reveals how men and women join together to become one whole person or half of what they could be. In women's groups women become aware of how they are oppressed in all their ego states; how their internal oppression as well as overt sexism keeps them down. Women have the opportunity in the groups to try out parts of themselves that they had not realized they possessed. The concept of the Pig Parent, the ego state that forms the powerful internalized oppressor, is discussed in some detail. The author writes of women's banal scripts that result in restriction of their autonomy and spontaneity, and she presents five common ones. For each of these scripts a thesis is presented that oppresses intimacy, spontaneity, and awareness, and the sad ending the thesis calls for is given. Wyckoff then relates some of the injunctions and attributions that keep women to these scripts, some of the mythical heroines of each banal script, how a traditional therapist colludes with the script, and, finally, the antithesis, or way out of it. She asserts that Rescue oppresses women by reinforcing passivity and their sense of impotence. A diagram of "the Drama Triangle" is presented that shows Victim, Rescuer, and Persecutor. Although the group can help, in problem-solving groups women must do their own work. The author notes that lack of strokes and intimacy is the most commonly reported oppression. She concludes that women need contact and support if they are to overcome oppression, and women in groups need strokes from other women.

V.

TREATMENT FOR SPECIFIC PROBLEMS AND POPULATIONS OF WOMEN



Specific Problem Areas
  - Alcohol/Drug Abuse
  - Depression
  - Marriage/Divorce
  - Motherhood/Mothering
  - Sexuality/Sexual Dysfunction
  - Work Related
  - Other

Special Populations
  - Lesbian Women
  - Minority Group Women
  - Women in Prisons

Specific Problem Areas

Alcohol/Drug Abuse

190.

Auken, Kirsten, and Arntzen, Bolette. On group therapy of medicine and alcohol abusing women. ***Acta Psychiatrica Scandinavica*** **(Kobenhavn), 39(Suppl. 169):400-401, 1963.**

Auken and Arntzen report on the group therapy approach they used with 12 medicine- and alcohol-abusing women at the State (mental) hospital at Glostrup in 1960-61. The participants ranged in age from 26 to 54 years; eight were married, two divorced, one widowed, and one single; and only three had not been employed while married. Four of the women had combined abuse of alcohol with medicine, and several used various drugs. The abuse history was 2 to 5 years for four women, 5 to 10 years for six women, and 10 to 15 years for two women. Influencing, encouraging, and helping one another were stressed in the group. Simply learning more suitable behavior and attitudes was considered a positive gain for the group members since the therapeutic objective was recognition of one's own problems. The authors describe a relaxed atmosphere within the group, which by satisfying a need for contact, decreased the group members' feelings of inferiority and guilt. A feeling of solidarity grew quickly, and it became important to adhere to the expected group standard of abstaining from medicine and alcohol. The group met 38 times over a 14-month period. The two therapists remained available to the group members if difficulties arose again after the group's termination. At the time of discontinuance of the group, five patients had had no relapse, and their prognosis was considered to be very good. The prognosis was also considered to be good for two patients who had had one relapse, but poor for the remaining five women who had had two or more relapses during the course of the group therapy. Reexamination 6 months later revealed similar conditions. Before group therapy and until the time of hospitalization, 10 of the 12 group therapy patients had already received another form of psychiatric treatment, but all had relapsed rather quickly. The authors conclude that they have obtained a good prognosis for one half of the patients they treated with group therapy. They consider this a positive outcome in view of the women's poor condition, but they indicate that whether group therapy is better, over all, than other kinds of treatment cannot be determined based on their small sample.

191.

Beckman, Linda J. Women alcoholics: A review of social and psychological studies. *Journal of Studies on Alcohol*, **36(7):797-824, 1975.**

This article examines the research since 1950 on the characteristics and treatment of women alcoholics, mainly in comparison to men alcoholics. Focus is on the social and psychological aspects of alcoholism. Variables considered include the following: family background, psychopathology in women alcoholics, differences between men and women alcoholics, why women become alcoholics, self-concept and self-esteem, specific personality traits, female sexuality, physiology and mood, and, finally, sex roles and role confusion. Much of the research available on these topics is conflicting; very little work has been done specifically with women, although women alcoholics do show differences from men in the pattern of their illness. They are more likely than men to have alcoholism in their family, and, generally, their background is also marked by a greater degree of disruption and deprivation. Women are more likely than men to turn to alcohol in response to specific emotional stress. Although men alcoholics also suffer from low self-esteem, studies suggest that women alcoholics have especially low self-esteem and may begin drinking because of a preoccupation with being inadequate and a sense of futility. Few treatment programs are geared primarily for women alcoholics, and most studies dealing with treatment effectiveness do not differentiate between men and women. Those studies that do make sex distinctions usually find a poor prognosis for women. Since data on treatment for women are also sparse and contradictory, the author recommends that future research use methodologies that allow the discernment of critical variables in female alcoholism if effective treatment is to be developed. Comparisons between women alcoholics and nonalcoholic "normal" women as well as nonalcoholic women undergoing psychiatric treatment would allow for an elaboration of differences that could be of significance in understanding the etiology of alcoholism in women.

In the interest of developing more effective treatment modes, the author also suggests the need for research that focuses specifically on the problems of low self-esteem and sex-role confusion and the need for womanliness. Other questions that deal more specifically with the differences among women alcoholics and between them and nonalcoholic women are also presented. Beckman concludes that study results should be applied to the development and assessment of new treatment approaches for women alcoholics.

192.

Borgman, Robert D. Medication abuse by middle-aged women. *Social Casework*, 54(9):526-532, 1973.

Borgman discusses the intervention of the staff of a community mental health center in the lives of 23 middle-aged women who substantially abused prescription drugs. Described as a homogeneous group, the women revealed a combination of ego maturity and extremely infantile themes. All of them exhibited middle-class standards of deportment, the ability to plan, and, except for their medication abuse, conventional impulse control. They were well educated by community standards, had stable marriages, and 12 of them had substantial employment records. Borgman indicates, however, that these women had an infantile core within their mature characteristics that manifested itself in several ways. They all expressed feelings of loneliness, unhappiness, and boredom, complained about lack of care from those around them, and presented themselves as helpless and hopeless. All reported multiple somatic complaints for which they had undergone extensive inconclusive medical evaluations. These complaints were the basis for their introduction to medications. Finally, all but three of the women took pleasure in provoking quarrels with other people. Borgman discusses and characterizes their relationships with other family members as "pathological hostile dependency." The acquisition, concealment, and ingestion of medication served real functions in the lives of these 23 women: (1) it formed a focus and organization for what they perceived as their empty lives; (2) for some, the offering of medication was equated with parental affection and nurturing; (3) it relieved their loneliness and boredom by eliciting excitement from physicians and family members; and (4) it was a means of expressing autonomy by opposing their families' wishes. Medication abuse was an outlet for these women whose propriety denied them other means of expressing unhappy life situations. The author briefly describes the intervention strategies, which were based on the assumption of considerable ego maturity in these women. The objective was to help the woman preserve or regain her maturity rather than to support her infantile themes. The women were helped to discover alternatives to drugs for relieving the loneliness, boredom, and lack of purpose they felt in their lives. Their sense of personal autonomy was fostered throughout the treatment. It was made clear to the women from the start that their use of the mental health clinic was their own choice and that obtaining or using medication and alcohol was their own concern. Additionally, they were helped to tolerate the frustration and pains of living.

193.

Burtle, Vasanti; Whitlock, Doris; and Franks, Violet. Modifications of low self-esteem in women alcoholics: A behavior treatment approach. *Psychotherapy: Theory, Research and Practice,* 11(1): 36-40, 1974.

A pilot project behavior modification program at the Women's Alcoholic Unit of the New Jersey Neuropsychiatric Institute was established in an attempt to restore the self-esteem of women alcoholics. Women were trained to perceive themselves in a new way, free from stigma and guilt for past actions. Additionally, they were trained in techniques of social interaction based on a sense of parity, which would enable them to deal with problem situations in the community. Seven black and nine white women participated in eight 1½-hour behavior modification sessions over a 4-week period. Only two of the black women were over the age of 40 in contrast to eight of the white women; the education of the black women ranged from 3 to 12 years, whereas that of the white women varied from 7 years to college graduation. Since the behavior modification program was mandatory in the treatment unit, no control group was used. Training consisted of a number of well-established behavioral techniques including relaxation, desensitization, and assertiveness training, along with the more innovative techniques of outcome reversal, the trade-last game, and desensitization to subject's own behavior. Participants were encouraged to attend Alcoholics Anonymous meetings and were also permitted to participate in other types of therapy, such as group discussions with the social worker and pastoral counseling. The following evaluative measures were administered at the time of admission into the program, at the close of the inpatient residence, and 16 weeks following return to the community: (1) The Taylor Manifest Anxiety Scale (1953), (2) The Internal-External (I-E) Scale (Rotter, 1966), (3) The Self-Assertion Scale based on a checklist drawn by Wolpe and Lazarus, and (4) seven scales and subscales of the Tennessee Self-Concept Scale (Fitts, 1965). The criterion of success was defined as (1) the capacity to remain abstinent (or to restore abstinence autonomously or with the help of Alcoholics Anonymous if a lapse of not longer than 2 weeks occurred) and (2) changes in the desired direction in the measures indicated above. At 16 weeks the followup questionnaires were returned by 10 of the 16 subjects. Of those who did not respond, two were evaluated as unsuccessful outcomes and four were determined to have restored abstinence on the basis of interviews, rehospitalization records, and information received by the social worker from alcoholism agencies or by family members' reports. Ten of the subjects demonstrated either total or restored abstinence; six of the women failed to remain abstinent. Regarding the evaluative measures, data for the 10 subjects who returned the questionnaires revealed that the statistically significant gains that had been made in assertiveness and in self-concept (5 of the 7 scales of the Tennessee Self-Concept Scale) by the end of the period of inpatient residence had been either eradicated or diminished after 16 weeks in the community. Only on three measures were statistically significant gains maintained (The Taylor Manifest Anxiety Scale) or achieved after return to the community (Family Self and Total Conflict Scales of the Tennessee Self-Concept Scale). The ratio of successful outcome favored the black women two to one. The authors also note that probability of success was inversely correlated with age, for subjects with successful outcomes had a mean age of 36.17 years compared to 47.50 years for those who did not remain abstinent. They claim that the pilot study reveals that positive and guilt-free self-perception can be promoted in only 12 hours of behavioral treatment—but that the task is complicated by the generally adverse effects of return to the community after treatment. Finally, the authors suggest teaching the woman alcoholic that it is not unwomanly to work. If she is provided with economic and emotional support while working skills are acquired, she may learn a way other than drinking to achieve the needed feeling of mastery and control over her own life that Lisansky (1974) identified.

194.

Calobrisi, Arcangelo. Treatment programs for alcoholic women. In: Greenblatt, Milton, and Schuckit, Marc A., eds. *Alcoholism Problems in Women and Children*. New York: Grune and Stratton, Inc., 1976. pp. 155-162.

In this chapter alcoholism is defined as "a progressive process of multiple etiologies characterized by remissions and relapses with a tendency toward chronicity." The increase in alcoholism among women is noted, and differences between alcoholism in men and women are summarized. Many housewives are secret alcoholics who, because of their own and their families' denial of the illness, often do not seek help until their disease has become chronic. The author suggests that if alcoholism is detected among women seeking help for other medical and psychic ailments, referrals to treatment programs that use women therapists should be made. Such referrals are identified as a means of avoiding the disadvantages of sex stereotyping in therapy. Calobrisi explains that the process of alcoholism for women can be divided into promodal, acute, intermediate, and chronic stages. He asserts that an effective treatment program should be able to use its various components to treat all stages. A team of physicians, counselors, and recovered alcoholics working closely with a medical facility is recommended to deal with all the stages of detoxification and recovery. Citizen efforts directed toward community participation and education in prevention and treatment of alcoholism, as well as toward making halfway houses available, are also identified as valuable. Psychotherapy, family therapy, spouse therapy, and counseling along with pharmacology and behavior therapy are described as useful treatment components. For the promodal stage the use of the medical model for early detection is suggested. Additionally, education and family counseling efforts may keep the illness from developing further. Most women are first seen at the acute stage, and at this point the aim is to restore physical health. This is generally done by means of detoxification in a hospital. The author suggests that after physical health is restored, the patient, while still in the hospital, should be exposed to an education and motivational regimen and should only be discharged with a definite therapeutic followup plan to help her through the pressures of readjustment. When treating a woman in the intermediate stage of alcoholism, the program presupposes she has already developed a workable insight into her illness and intervention is directed toward psychological integration, removal of the impairment, and total abstinence. In addition to various forms of therapy, membership in Alcoholics Anonymous is suggested as a way to increase chances for recovery. When the disease has progressed to its chronic stage, conventional approaches prove useless and the environment and alcohol intake have to be controlled. Halfway house-like arrangements are described as most successful in reversing the process of the illness to the intermediate phase, but complete recovery is rare. The author concludes that more outcome and comparative studies on women alcoholics are needed as well as research on chemotherapy. He notes that treatment programs can only improve through a continued search for a rational etiology.

195.

Coleman, Ben Ivor. Helping women addicts in New York City. *International Journal of Offender Therapy and Comparative Criminology*, 18(1):82-85, 1974.

Coleman discusses a program initiated by the New York City Departments of Health and Correction to provide weekly group therapy in the House of Detention to pregnant women with a history of drug abuse. An operating premise was the need to help drug addicts with almost every aspect of their lives in order to give them a realistic hope for the future. A multidisciplinary team including a public health physician and nurse consultant, a pediatrician, the chairwoman of Narcotics Anonymous, and a social work consultant (the author) participated in the sessions. The primary goal of these meetings was to make the future mothers aware of community resources and how to use them. Relationships were established so that the women had people to turn to on their release to the community, and plans for their future were discussed. The author reports that after 2 to 3 years of these group sessions, plans evolved for a day and night center to provide overall services for mothers and infants and a comprehensive service for mothers at risk. The goal was to provide security to the infant and mother by ensuring good continuing care so that mothers who kept their children would be able to provide for them. The plan for this program is presented. Coleman suggests that care should not be limited to incarcerated women, and he notes that efforts are being made to trace all mothers in New York City with histories of drug addiction. Coleman indicates that detoxification must be accompanied by intensive reality counseling and continued help in moments of crisis so that women can build more positive self-images and orient themselves toward the future. The overall aims of the program are identified (1) ensuring good care and supervision for the infant, (2) maintaining the drug-free condition of the mother, and (3) educating the family about the importance of continuing health care and supervision. The author reports that because the facilities for carrying out these programs were very limited, the program was "marking time awaiting decisions for overall policy and program planning." However, Coleman indicates that even with such fragmented and insufficient services, a number of women have been helped. Three case histories of women who participated in the group sessions at the House of Detention are provided.

196.

Craig, Sara. Help for women alcoholics. *Opportunity*, **2(5):19-23, 1972.**

The Family Activity Center, a day care program for women alcoholics, is described. Most of the women using the service are poor, heads of households, and black. Entirely voluntary, the program is both an adjunct of and a bridge to and from the extensive Alcoholic Rehabilitation and Recovery Program operated by Economic Opportunity Atlanta. The Family Activity Center serves the woman alcoholic who does not want a domiciliary facility but who may need a supportive environment during the day for an interim period. Services are geared to the woman who has already demonstrated her desire to overcome alcoholism by contacting one of the seven Storefront Alcoholic Centers of the Alcoholic Rehabilitation and Recovery Program. She has been "detoxified" and given other treatment as indicated; she has been made aware of and may already be attending Alcoholics Anonymous meetings; and she has received counseling and other services appropriate to her special needs. Yet, as she may not feel prepared to return to her old environment or to undertake a job, the Center attempts to help her through this interim period and assist her in developing a new lifestyle. A psychiatric social worker provides individual counseling on a regular basis as well as group counseling sessions twice a week. Educational and recreational activities, which are designed to be both therapeutic and useful, are also available. The atmosphere is relaxed and supportive, instructive and outgoing rather than introspective and problem oriented. The story of one alcoholic woman who used the services of the Center is recounted. The Center's four staff members and their work efforts are described. Although child care facilities are available within the Center, it is felt that in the early stages most women need daytime hours away from their children. Accordingly, until a later phase of the women's participation at the Center, arrangements have been made for referral of the children involved to a day care center. A typical day at the Center is described.

197.

Curlee, Joan. Women alcoholics. *Federal Probation*, 32(1):16-20, 1968.

Based on a review of the literature, Curlee reports some of the distinctive characteristics of the etiology and progression of alcoholism in women. She also points out some of the serious gaps in our present knowledge. Although there is little research on the female alcoholic, Curlee indicates that the public has a very clear and more degraded stereotype of her than of the male alcoholic. A possible explanation for this phenomenon is that since the role of women is to provide the stabilizing functions of wife, mother, and keeper of the home, a drunken woman poses a special threat. Alcoholism seems to connote a more serious pathology in women than men, perhaps because the taboo against it is so much stronger. Women alcoholics do not appear to turn to alcohol for the same releases sought by men. In women, role confusion is considered a major factor in the etiology of alcoholism. Alcoholism is more likely to be related to specific situations in women's lives than in men's, and the relationship of alcoholism to women's physiological functions has been noted. Curlee suggests that this latter relationship may be caused by factors that make it difficult for women to accept their distinctive physiological functions rather than by the functions themselves. She discusses the special difficulties alcoholism poses for married, single, and career women in this society. Although the stereotyped alcoholic woman is thought to behave promiscuously, frigidity is a more likely psychosexual problem for her. The author notes that the majority of women alcoholics are "respectable" women who drink at home, but the negative stereotype persists and creates a special problem in the recovery of these women, who share society's degraded perception of themselves. Curlee points out that counseling efforts directed to alcoholic women must include a realization of their low self-esteem, for only when women begin to identify themselves as worth helping can they begin to accept help. Women also have treatment problems, because the stigma against alcoholic women makes it more difficult for them to seek help. Even when they do seek help, most facilities are geared to working with men and use structures, such as groups, that seem less effective with women. In discussing the alcoholic woman and her family, the author indicates that a major factor in an alcoholic's recovery is the attitude of those who are closest to her/him and that the treatment of alcoholic men and women by their spouses is likely to differ because of their different roles. The author concludes that although female alcoholism has received less attention than it requires, the facts available indicate that alcoholism in women differs sufficiently from that in men to imply that there are significant differences in treatment needs.

198.

De Leon, George. Phoenix House: Psychopathological signs among male and female drug-free residents. *Addictive Diseases: An International Journal*, 1(2):135-151, 1974.

Noting a dearth of information on sex differences in outcome of drug-free treatment programs, De Leon investigated the relationship of sex to other factors such as psychopathology, ethnicity, and dropping out versus completion. Subjects were 148 male and 60 female participants in the Phoenix drug treatment program who were comparable on demographic characteristics. Paper-and-pencil tests of psychopathology indicated that although this population as a whole shows significantly elevated scores, this finding was significantly higher for females. Psychopathology scores of both males and females decreased with progress in the program, but females continued to have significantly higher scores than males. This finding was replicated in a longitudinal followup of 83 residents retested 7-½ months after the initial testing. Dropouts (40 percent of the males and 47 percent of the females) had consistently higher scores on three psychopathology indices than those who remained, but sex differences were evident here too: female dropouts had higher Beck Depression Scale scores than males. White subjects had higher pathology scores than Hispanic or black subjects, but females in each group were consistently higher than males on all but one scale. Means were lowest for black males and females. Largest within-group sex differences were found among the Hispanic and the smallest among black subjects. The author postulates that for women, especially white and Hispanic women, a more serious psychological disturbance may underlie the addiction. He suggests that addiction appears to be a less psychologically "sick" behavior for black males and females than for all whites and for Hispanic females. Firmer conclusions require the use of matched nonaddict controls and clinical validation of indicators of psychopathology. Understanding of addiction and its treatment also requires clarification of psychological sex-related differences.

199.

Densen-Gerber, Judianne. The women's marathon. In: Densen-Gerber, Judianne. ***We Mainline Dreams: The Odyssey House Story.*** **Garden City, N.Y.: Doubleday and Company, Inc., 1973. pp. 321-337.**

This is a very personal account of a marathon conducted for young women at Odyssey House, a drug treatment community. The author notes that female addicts are very different from males. They are generally sicker, more difficult to treat, and rarely have a sense of female identity. Odyssey House was successful in treating women only when there was a strong female role model working directly with them. When the usual dynamic of society was allowed to operate and the women were relegated to inferior positions, they became discouraged and started to leave the program. Treating addicted adolescents in a coeducational facility was also found destructive to girls because of the sexual puppy play that occurred. Better results were achieved when male and female adolescents were treated separately. The Women's Marathon described was initiated because of the author's desire to develop closer relationships with the girls in the program and to give them all a chance to "be female together." It was planned as a typical marathon—running for 24 hours with a 6-hour sleep break and then going for 12 additional hours in a very informal setting. The marathon began with most of the girls expressing their fear, inability to trust anyone, and uncertainty about how they felt about being female. The article describes the course of the marathon and the interactions that occurred within the group as the participants dealt with their emotional experiences as females. Some of the specific topics dealt with were pregnancy, abortion, childbirth, fear of not being able to bear children, prostitution, and the problem of accepting one's identity. Most of the participants in the marathon were under age 17, but they had already experienced many unpleasant relationships with men and were filled with self-loathing. They dealt with the necessity for having self-esteem and knowing how to set limits to keep from being abused. In addition to the opening up and sharing of experiences, the thrust of the marathon was the message that each person has within her the strength and the responsibility for making changes in her life.

200.

Eldred, Carolyn A.; Grier, Velma V.; and Berliner, Nancy. Comprehensive treatment for heroin-addicted mothers. *Social Casework*, 55(8):470-477, 1974.

A joint counseling project for heroin-addicted mothers was undertaken by the Narcotics Treatment Administration and the Social Rehabilitation Administration of the District of Columbia in the summer of 1972. The project responded to the concern workers felt for children of addicts referred to them in crisis situations and their inability to reach and understand the addict parents. Ten pairs of clients undergoing methadone maintenance treatment were selected and closely matched on the variables of sex, race, family size, and age of children. One member of each pair was randomly assigned to the treatment group and the other to the control group. The one man in treatment dropped out early in the program. One pair of women was white, the others black. They ranged in age from 20 to 38 and had been addicted between 2 and 7 years. Each treatment client was referred to a social worker at the Social Rehabilitation Administration. The social worker established a close relationship with the addict mother and her significant others through counseling and securing services for them. The social worker's clear concern about the women is identified as contributing to their self-esteem. All the clients were operating on a very infantile level, and the ramifications of this and their close ties to their parent figures are discussed. The initial thrust of the contact was to reassure the women of their self-worth. The Narcotics Treatment Administration counselor and the Social Rehabilitation Administration caseworker kept in close touch as the clients simultaneously progressed through both treatments. The authors warn that the small size of the study requires that it be regarded as exploratory in nature and that its findings be considered tentative. Statistics are presented on the progress of the two groups after 8 months of treatment. The treatment group had made significantly ($p < .02$) more visits to the Narcotics Treatment Administration Clinic and had only half the proportion positive urines (i.e., indicating drug use) as did the control group. Some of the treatment clients' positive personal evaluations are also presented. The success of the treatment approach is considered to be a function of the caseworker's help in solving practical problems; her ongoing contact, which communicates caring and stimulates the client to try to stay in treatment; and the therapeutic process, which may improve the client's psychodynamics as well as the interpersonal dynamics of the family unit. The authors discuss the use of halfway houses and paraprofessionals in future treatment programs and conclude that the comprehensive and holistic approach of family- and community-oriented treatment could benefit all clients.

201.

Eldred, Carolyn A., and Washington, Mabel N. Female heroin addicts in a city treatment program: The forgotten minority. ***Psychiatry*, 38(1):75-85, 1975.**

This descriptive study attempted to characterize a group of female and a group of male heroin addicts, with special attention to sex differences. It was hoped that results might suggest a basis for modification of male-oriented treatment programs. A structured interview schedule was used with 79 female and 79 male clients at the time of their entrance into a treatment program. Mean age was 24.96 for the females and 24.94 for the males; all but 11 percent of the females and 3 percent of the males in the program were black. Statistically significant differences were found between the men and women in life situations and the matrix of social relationships within which drug use occurred. Sex differences were examined in relation to the following areas of concern: drug use, marital status and living situation, children of the clients, plans for additional children and pregnancy, employment and schooling, and sex of treatment personnel. The following picture of the female addict emerged: she is likely to be unemployed and receiving no financial assistance, currently single, to have children who may or may not be living with her, and to want no more children in the immediate future but to fail to use contraceptive methods consistently. The authors encourage those who treat women addicts to be alert to these areas and to investigate their importance for each individual woman they treat. The prevalence of motherhood among the women in this sample is felt to be the most noteworthy finding of the study. The greater role of children in lives of most of the female clients may have a variety of ramifications for their rehabilitation. Concern for her children or a desire to retrieve them from the care of others may motivate a woman to give up drugs and to try to become self-sufficient. It is also possible that the pain the woman addict suffers because she is unable to rear her own children or the efforts she needs to make to resume her parenting role may create additional pressures for the addict mother. Similarly, the responsibility for children in her care may create stresses that are not experienced by most male addicts. The authors conclude that problems related to children should have a larger role in the treatment of female addicts. They suggest that possible efforts to deal with this concern might include the provision of psychological support for the mother's attempts to deal with parental tasks, assistance in solving practical problems and securing services related to child rearing and instruction in skills involving care of themselves and their children, familiarizing heroin addicts with the effects of drug use during pregnancy, making child-care facilities available, and encouraging female clients to make informed decisions about future pregnancies.

202.

Gioia, Carolyn, and Byrne, Rebecca. Distinctive problems of the female drug addict: Experiences at IDAP. In: Senay, Edward; Shorty, Vernon; and Alksne, Harold, eds. *Developments in the Field of Drug Abuse: Proceedings 1974 of the National Association for the Prevention of Addiction to Narcotics.* Cambridge, Mass.: Schenkman Publishing Company, Inc., 1975. pp. 531-538.

The distinctive characteristics and problems of female addicts seeking treatment at the Illinois Drug Abuse Program are examined. The typical woman addict entering the program is described as black, single, a mother whose children are not living with her, unemployed and without vocational skills and education, and an isolated and lonely person who is unable to establish stable love relationships. The study consisted of questionnaires administered in the fall of 1972 to a sample of 78 persons, and interviews conducted in the summer of 1973 with 35 persons in the Illinois Drug Abuse Program—males and females, staff and patients, from 12 clinics. Thirty males and 16 female patients were in the questionnaire sample, and 9 males and 12 female patients were in the interview sample. Questionnaire subjects were randomly selected from the listing of names on the population sheet. Interview subjects were selected at random from the category desired (e.g., female staff or male patient). There is no mention of staff responses in the discussion, although it is indicated that they are included in the sample. Male and female characteristics were compared on several items. In the two samples 63 percent and 44 percent of the male patients claimed to be employed, in contrast to 9 percent and 8 percent for the women. All 12 women interviewed, however, spoke extensively about past job experiences and their difficulty in keeping a job. For more than half the women, obtaining a job was a major goal of treatment. In contrast to the men, many women appeared to evaluate both themselves and their treatment in terms of their ability to take care of themselves and their children by obtaining employment. All interviewed patients indicated that the program had been helpful. Five of the 12 women and 6 of the 9 men identified the groups as the most helpful aspects of the program. The therapeutic community and the counselors were also seen as helpful. Seven of the women but none of the men indicated that methadone had helped them. Four men but only one woman considered informal contact to be an important aspect of treatment. A distinctive pattern—"what helps me also hurts me"—emerged during interviews with 7 of the 12 women but with none of the men. The women frequently express ambivalence about their dependent position, which they experience as a result of being a black woman and an addict in this society. Examples are given of the ambivalence of different women patients concerning methadone and other aspects of treatment. The authors discuss this ambivalence at length, noting that whatever its sources, some of the distinctive problems of the women in the program appear to be related to a simultaneous need for dependence and independence. They speculate that this ambivalence may be a potential source of strength for many of these women, for eventually treatment must consist of recognizing and integrating both independence and dependence. Additionally, they suggest the possibility that a corresponding difficulty for the men in treatment may be a lesser ability to recognize the combination of these needs.

203.

Gomberg, Edith S. Women and alcoholism. In: Franks, Violet, and Burtle, Vasanti, eds. ***Women in Therapy: New Psychotherapies for a Changing Society.*** **New York: Brunner/Mazel, 1974. pp. 169-190.**

In this chapter on women and alcoholism, alcoholism is defined as deviance from the accepted social customs relating to drinking. Although it has become as acceptable for women to drink as men, a double standard continues to apply to drunkenness. This double standard may stem from drunkenness interfering with the woman's role as caregiver to her family or from the widespread belief that drunkenness leads to lewdness. Histories of alcoholic women profile them as victims of early emotional deprivation, simultaneously submissive and resentful. Adolescence is a stormy time for them. They have difficulty controlling their impulses, and they grow up fearful of dependency relationships while trying to solve their problems with a superfemininity. In discussing the sexual role of alcoholic women, Gomberg notes that the relationship between physiological and emotional factors and alcoholism has yet to be worked out, although women alcoholics seem to have a high incidence of gynecological disorders. Women alcoholics tend to overemphasize and place a great deal of value on femininity and the wife-mother role. However, when their unconscious attitudes were measured, they have been found to reveal less "femininity" and more interest in what can be labeled more masculine concerns. As the female alcoholic is usually driven to seek therapy by her family and interpersonal problems, concentration on the family has proven more effective than individual therapy. For women with children, dealing with the children's problems is often therapeutic for both mothers and children. Although group therapy seems to be less effective for women alcoholics than for men, smaller mixed groups are believed to be preferable when this is the chosen approach. Gomberg suggests that the psychotherapist needs to focus on the function alcohol is serving for the patient. It may be a way of expressing anger or of providing her with a feeling of control over her own life or any number of other possibilities. The assets of the patient who seeks help and the involvement of the therapist are considered more important than the mode of therapy that is used. Studies show conflicting findings as to whether the prognosis for women alcoholics is different than for men. The female alcoholic's problems are identified as revolving around her sex role and making that role work. Noting that women are more likely to give causes for the onset of drinking than men, Gomberg suggests this may mean that alcoholism in women is a reactive rather than a process disorder and should have a better prognosis. Some data on the wives of alcoholics are also presented.

204.

Kilmann, Peter R. Marathon group therapy with female narcotic addicts. *Psychotherapy: Theory, Research and Practice*, 11(4):339-342, 1974.

Kilman reports on his evaluation of the effects of structured and unstructured marathon therapy on institutionalized female narcotic addicts. Eighty-four women were randomly assigned to one of five groups—two structured therapy groups, two unstructured therapy groups, or a no treatment control group. In the structured groups, the goals, methods, and time devoted to each component of group function were controlled by the therapists; the therapists relinquished primary responsibility for the group's functions to the members in the unstructured groups. Each group had one Ph.D. level psychologist and one master's level junior therapist. None of the therapists knew the purpose of the experiment, but they were informed of the experimenter's expectations of the format of their respective marathon groups. The test instruments used were the Personal Orientation Inventory (Shostrum, 1966), the Adjective Checklist (Gough and Heilbrun, 1965), and a measure of self-ideal congruence (Howell, 1969). Noting the lack of research, Kilmann relates that prevailing clinical impressions suggest that female as well as male addicts reflect sociopathic tendencies, difficulty with impulse control, and an inability to postpone gratification. On this basis, it was assumed that male and female narcotic addicts reflect similar personality characteristics, and unidirectional predictions were made on the criterion scales of the test instruments. The marathon group lasted for 23 hours. All subjects were given the battery of tests before and immediately after participating in the marathon groups. Kilmann indicates that the comparison between the marathon groups and the no-treatment control group yielded significant ($p < .05$) results in favor of marathon therapy on the "Self-Control" and "Achievement" items of the Adjective Checklist Scale. "Time Competence" on the Personal Orientation Inventory scale approached statistical significance in favor of marathon therapy, and "Nurturance" on the Adjective Checklist was significant ($p < .05$) in favor of unstructured therapy when structured and unstructured groups were compared. Kilmann notes that compared with the control group, marathon participants had become more interested in their obligations and were making more effort to succeed. As narcotic addicts have been reported to experience difficulty in impulse control and a lack of persistence in dealing with their problems, he contends that the addicts participating in the marathon group may reasonably be said to have experienced therapeutic change. Results of the comparison between the structured and unstructured treatment groups do not permit conclusions to be made about the benefits of one treatment over another. In concluding, Kilmann claims that positive verbal feedback from the marathon participants and from the counselors concerning subsequent behavior of participants in weekly group sessions attest to the subjective impact of the marathon group approach.

205.

Mayer, Joseph, and Green, Monroe. Group therapy of alcoholic women ex-prisoners. *Quarterly Journal of Studies on Alcohol,* **28 (3):493-504, 1967.**

A male leader held 24 weekly group therapy sessions with alcoholic women ex-prisoners at the Peter Bent Brigham Hospital Alcoholism Clinic. The group began with 10 members who ranged in age from 31 to 48. Attendance varied from none to five; there were two or three members at the average meeting. The women are described, and two representative case histories are presented. The difficulties encountered and the therapy results are discussed in terms of the initial, middle, and final periods of the group meetings. In the first six sessions, group content focused on anxiety about attendance at the group sessions and concerns about prison. Prison proved to be the only comfortable discussion area for the group. When a woman talked of her personal problems, the other group members would become uncomfortable and silent. Most of the feeling and activity in the group was directed to the leader; the members rarely interacted with one another, and then, only tentatively. The introduction of five new members between the seventh and fifteenth sessions resulted in an essentially different group, but the old patterns of response continued. In an effort to help the women become a cohesive unit, common problems of adjustment and drinking were discussed, but there was little overt response. New members were rejected and ignored by the old, thereby forcing the leader to give more attention to the new members. Consequently, a group-defeating cycle was ever present. During the last eight sessions, the group was dissolving, and content at this time was on the feelings and problems of individual members. Desire for sole possession of the leader intensified, and demands for individual therapy with the leader were openly expressed. Discussing the ineffectiveness of group therapy with these women, the authors identify the major problems as erratic attendance; low membership; intense, difficult to manage transference; volatility and orality of the women; and lack of controls. They conclude that despite the problems of running the group and the decision to disband, the group did have some value for the women. It was a place for these lonely and isolated women to go, and it fulfilled the two goals of outpatient treatment that have been identified for this group. It accomplished the transfer from the prison to an outpatient setting, and it enabled the women to use outpatient treatment facilities after this group had terminated.

206.

Mayer, Joseph; Myerson, David J.; Needham, Merrill A.; and Fox, Marion. Treatment of the female alcoholic: The former prisoner. *American Journal of Orthopsychiatry*, 37(4):932-937, 1967.

The results of the first 7 years (1958-65) of an outpatient treatment program for the rehabilitation of female alcoholic former prisoners are reported. The keystone of the hospital alcoholism clinic program is that a staff member establishes a relationship with the patient while she is still in prison and then introduces her to a new therapist at the clinic after her release. In contrast to the poor response to previous programs for alcoholic ex-prisoners, the study found that 52 percent of the women contacted continued in the treatment program after their release. The alcoholic women prisoners treated in this program had more severe problems than other women referred to the clinic, and these are discussed. A theme of erratic loss of control dominated their lives, and most were severely disturbed with few social or family resources. They required special help that focused on the management of repeated crises. Of the 75 women prisoners seen during this 7-year period, 26 (35 percent) maintained only brief contact with the clinic and almost all of this group returned to drinking and disorganized living. Thirty (40 percent) of the women allowed the clinic and the hospital's medical resources to assist them with numerous crises, but, despite continued contact, they displayed no consistent improvement in functioning. Of the 75 women, 19 (26 percent) were aided in similar crises and did show marked improvement in their day-to-day functioning. The focus of the therapy was active intervention and support in times of crisis. Two case histories are provided to illustrate the nature of the crises these women present. The authors indicate that the program's initial goal of enabling larger numbers of female alcoholic ex-prisoners to receive outpatient medical and psychiatric care was accomplished, although therapeutic goals, such as abstinence and adequate social and economic functioning, proved unrealistic for this highly disturbed group of women. The authors state that in treating such patients, therapists must be willing to assume as much control over the patient's life as she wishes or allows, while always acknowledging the patient's right to make her own choice, even if this choice jeopardizes her life. The patient's willingness to allow this control is based on trust that is established by the therapist's consistent willingness to help and his/her respect for the patient's freedom. Contending that the therapist must be willing to intervene in all aspects of the patient's life, the authors acknowledge that this practice creates a dependency. Dependency is considered preferable, however, to the alternative of self-destructiveness that the denial of help would foster. Although there are great difficulties in treating these women, the authors suggest that this program provides a needed alternative to incarceration or aimless drifting.

207.

Ross, Wesley F.; McReynolds, William T.; and Berzins, Juris I. Effectiveness of marathon group therapy with hospitalized female narcotic addicts. ***Psychological Reports*****, 34(2):611-616, 1974.**

The authors compared the effectiveness of a 17-hour marathon experience with that of daily 2-hour group therapy in women narcotic addicts hospitalized in a National Institute of Mental Health facility. Six volunteer marathon subjects were matched as closely as possible for length of withdrawal, age, verbal intelligence, and drug abuse history to the six control subjects who received the facility's usual group psychotherapy. Group leaders were male—two clinical psychologists for the marathon group and one clinical psychologist and a social worker for the control group. In both groups the primary emphasis was to begin the group psychotherapy process and to have the group members interact meaningfully concerning their problems. The Lexington Personality Inventory, which includes Minnesota Multiphasic Personality Inventory (MMPI) clinical scales, addict identification scales, Edwards Social Desirability Scale, Barron Ego Strength Scale, and Rotter's Locus of Control Scale, was given 1 week before therapy and 2 weeks after completion. Both groups showed significant pre-post changes on the MMPI neurotic triad and significantly more increased internal control. The marathon group showed a decrease in favorable attitudes toward themselves as drug addicts and toward the criminal subculture, whereas control subjects showed a slight increase on these measures. The study revealed that both approaches had equal effectiveness in terms of MMPI-rated neurotic complaints, but the marathon group was differentially effective in modifying attitudes toward drugs and criminal subculture. Marathon subjects had a better outcome at 12-month followup, but the findings were confounded by the group therapy they continued to receive after the investigation.

208.

Schultz, Ardelle M. Radical feminism: A treatment modality for addicted women. In: Senay, Edward; Shorty, Vernon; and Alksne, Harold, eds. *Developments in the Field of Drug Abuse: Proceedings 1974 of the National Association for the Prevention of Addiction to Narcotics.* Cambridge, Mass.: Schenkman Publishing Company, Inc., 1975. pp. 484-502.

Schultz states the case for a radical feminist approach to addicted women. To this end, she draws on her own life experience, her first attempt to gain treatment rights for women in a rehabilitation center, and her current 2-year experience as director of therapy in a drug treatment and rehabilitation program for young adults. According to Schultz, the radical feminist approach, which challenges traditional methods of treatment, seeks to obtain the right for women to be treated for what they are rather than for what male-dominated institutions and professions think they should be. In relating her own life experiences, Schultz focuses on her socialization to accept the standard feminine role, the stresses of a modeling career, her nervous breakdown, contacts with psychiatrists, a nonvoluntary hospitalization, her alcoholism, and her days as a housewife. Schultz's developing identification with other women and their problem with anger led her to a job at the rehabilitation center. Describing her 18 months of work with the drug and alcohol dependent women in the center, she elaborates on the problems encountered and her first efforts to gain treatment rights for women. Effort focused on keeping the 13 women who found themselves among 110 men together; stopping the use of the women for sex itself, as hostesses at community meetings, for kitchen work, and as sex-role models for the men in therapy groups; and establishing an all-women's therapy group with a woman therapist to function as a role model. Schultz also discusses the special concerns of the women from minority groups and the problems posed by motherhood. She reports on the success of her treatment efforts and relates that the male community reacted to her efforts and success by asking her to leave. Discussing her current experience at TODAY, Inc., she notes that a first step in the development of their treatment program for women was the hiring of a woman therapist and the establishment of separate male and female therapy groups. Learning from the past, Schultz identifies the importance of talking with male staff and residents about men's and women's problems and reaching agreement that women need "special treatment." She reports on the self-help concept at TODAY, indicating that the "slip-group" (a technique for learning how to deal with anger) and the work structure are particularly beneficial to women. Residents are encouraged to deal with their feelings in slip-groups—the first time that many women have been allowed to express anger. The residents manage all four departments of the house's operation—kitchen, housekeeping, maintenance, and public relations—with assignments and promotions made on the basis of ability rather than sex. Schultz also describes a "learning experience," which is used to help women deal with their identity and self-worth problems, and discusses the problems of women addicts who are also lesbians. Since the radical feminist approach for women can be translated into a nonsexist approach for all addicted individuals, she discusses the issue of equality of treatment for men that was raised and dealt with at TODAY. She concludes that the research statistics for the TODAY treatment program reveal success—a radical feminist approach does work.

209.

Silver, Frances C.; Panepinto, William C; Arnon, Dan; and Swaine, William T. A family approach in treating the pregnant addict. In: Senay, Edward; Shorty, Vernon; and Alksne, Harold, eds. *Developments in the Field of Drug Abuse: Proceedings 1974 of the National Association for the Prevention of Addiction to Narcotics.* Cambridge, Mass.: Schenkman Publishing Company, Inc., 1975. pp. 401-404.

The Family Maternity Clinic's comprehensive treatment program for pregnant addicts and their husbands is described. The immediate and long-term goals of the program are to bring stability to the pregnant addict's life situation and to help her become a consistent and loving parent. The crisis situation of pregnancy is used to help the woman give up the drug life and clarify her roles as a mother and as a woman. The staff works to create the atmosphere of an accepting family. Informal patient-staff contacts and the provision of role models for the patient are an established part of the program along with formalized groups and individual counseling sessions. The authors report that the intervention during pregnancy was successful in changing the addict's lifestyle during this time. If these changes were to be maintained, however, the women required some way of satisfying their own needs as they performed the tedious daily tasks of child care and experienced the difficult periods of child rearing. In order to provide some support, changes were instituted throughout the program to strengthen the family relationships. These included adding a child psychiatrist to the program who trained staff to work with parent-child problems and overall family functioning, scheduling family sessions with all members of the pregnant addict's household at the time of admission, and initiating child-care classes that focused on discipline, personal hygiene, and demonstration of feelings. The authors point out that as a male is only admitted into the program with his partner, the women take a leadership role in obtaining treatment. For many women, this is the first change in their pattern of dependency on their men. The peer group within the clinic plays an important role in the participants' acquiring feelings of self-worth. Groups are supportive of the women's desire to take time for themselves and of the concept that the women need not live their lives for their children. Women who want jobs are encouraged to follow courses of training in areas that interest them. Methadone in low dosages, leading to abstinence, is provided to those patients who consider medication necessary for success in treatment. A significant movement away from drug dependency is reported. The authors relate that continued supportive and educative treatment has resulted in improved psychosocial stability, especially in the area of maternal role functioning. This improvement has been accompanied by a steady increase in feelings of self-esteem and self-worth.

Depression

210.

Bart, Pauline B. Depression in middle-aged women. In: Gornick, Vivian, and Moran, Barbara K., eds. *Women in Sexist Society: Studies in Power and Powerlessness.* New York: Basic Books, Inc., 1971. pp. 163-186.

Bart used anthropological and epidemiological data along with interviews with projective tests to study depression among middle-aged women. To test the hypothesis that depression in middle-aged women was the result of the behavioral changes of menopause, a cross-cultural study was conducted of 30 societies using the Human Relations Area Files, and six cultures were intensively examined using the original anthropological monographs. The records of 533 hospitalized women between the ages of 40 and 59 who had no previous record of hospitalization for mental illness were reviewed. Twenty intensive interviews were conducted at two hospitals to obtain information unavailable from patient records, to give the women questionnaires used in studies with "normal" middle-aged women, and to administer the projective biography test, which consisted of 16 pictures showing women at different stages in their life cycles and in different roles. Maternal role loss was recorded when at least one child was not living at home. A relationship was considered to be overprotective or overinvolved when a statement such as "my whole life was my husband and daughter" was written on the woman's record or if the woman entered the hospital following the marriage or engagement of a child. The author reports and discusses the following findings: (1) depression in middle-aged women was due to their lack of important roles and subsequent loss of self-esteem and was not a result of the hormonal changes of menopause; (2) role loss was associated with depression; (3) role loss cannot be compensated for by the expansion of other roles; (4) certain roles appeared to be structurally conducive to increasing the effect of the loss of other roles; (5) there existed a higher rate of depression among middle-class housewives than among working-class housewives, and those housewives who had overprotective relationships with their children experienced the highest rate of depression when the children left home; (6) depression among women with maternal loss was related to the family structure and to the typical interactive patterns of a woman's ethnic group; and (7) when ethnic groups were compared, Jewish women had the highest rate of depression, Anglos the next highest, and blacks the lowest rate—but, when interactive patterns were controlled, differences between Jews and non-Jews markedly diminished. Bart concludes that the data reveal that the women who have assumed and accepted the traditional norms, who stay married to their husbands, and who are not particularly aggressive are the women who become depressed when their children leave home. Alternatively, if a woman's worth is based on her own achievements and is not dependent upon others, she is less likely to experience a breakdown when those significant others leave. Bart suggests that the women's liberation movement can help both men and women to develop fully by pointing out the possibility of alternative lifestyles, by giving the emotional support necessary when other than ascribed sex roles are chosen, and by emphasizing the importance of women fulfilling their own potential.

211.

Beck, Aaron T., and Greenberg, Ruth L. Cognitive therapy with depressed women. In: Franks, Violet, and Burtle, Vasanti, eds. ***Women in Therapy: New Psychotherapies for a Changing Society.*** **New York: Brunner/Mazel, 1974. pp. 113-131.**

After establishing that depression is a health problem of some magnitude for women, this article defines the four types of interrelated symptoms in depression—emotional, cognitive, motivational, and behavioral. Various theories of depression as an expression of a sense of helplessness and powerlessness (Bibring, 1953; Gaylin, 1964; Sarwer-Foner, 1968) are reviewed. Also examined are Chesler's (1972) theory, which considers depression merely an intensification of traits the normal socialization process brings out in women (passivity, self-deprecation, fearfulness, and a normal response to the realities of oppression) and Jessie Bernard's (1972) theory, which attributes depression to the "bad deal" women get in marriage. The authors suggest that behavioral and cognitive theories present a more optimistic view than the one feminists hold for psychotherapy's ability to deal with depression. The behavioral school recognizes depression as the result of a lack of sources of positive reinforcement, and the behavior therapist works to change the depressed patient's behaviors in order to increase the level of positive reinforcement she receives. Cognitive theory considers the cognitive manifestations of depression as playing a primary role and seeks to alter the patient's negative views of self, the outside world, and the future. The authors suggest that cognitive therapy with its techniques for altering depressed cognitions has a unique view of women's problems as described by the feminists. Cognitive theory identifies women's depression as due to their perceiving themselves as helpless, repressed, and dependent, irrespective of whether this is objective fact or not. The cognitive therapist is actively involved in the initial interview to formulate the problem on the basis of overt symptoms, to establish goals, and to develop specific operations to deal with each problem area. Working with the patient, the cognitive therapist formulates the presenting symptoms in terms of basic misconceptions and thought patterns which become obvious as the patient relates her spontaneous thoughts and experiences. The patient is trained to become aware of her "automatic" idiosyncratic thoughts and taught to distance herself and to view her thoughts objectively so that the depressive spiral of event, automatic thought, and affect can be halted. Work is also done to expose and evaluate specific cognitive difficulties, such as misconceptions and prejudices, that the therapist observes. The authors note that behavioral techniques, such as graded task assignments, may also be used to change the depressed cognitions. In cases of severe depression, cognitive therapy is used chiefly in conjunction with supportive therapy. The authors conclude that women will only make progress if they take full responsibility for mastering their circumstances, acquire self-respect and self-reliance, and learn to lead more balanced lives. They conclude that women can educate themselves to recognize cultural prejudices for what they are and not have their self-evaluation be altered by them.

212.

Covi, Lino; Lipman, Ronald S.; Alarcon, Renato D.; and Smith, Virginia K. Drug and psychotherapy interactions in depression. *American Journal of Psychiatry*, 133(5):502-508, 1976.

Predictors of women's response to different treatments for depression were sought. The six types of treatment compared included the following: group psychotherapy with placebo, minimal supportive psychotherapy with placebo, imipramine in combination with group therapy, imipramine in combination with minimal supportive psychotherapy, diazepam in combination with group psychotherapy, and diazepam in combination with minimal supportive psychotherapy. The 212 women in the sample were clients at two psychiatric clinics in Baltimore, Md. The subjects had agreed to participate in the study. They had a depression severity score of at least 7 on the Raskin Depression Scale, were nonpsychotic, and ranged in age from 20 to 50 years old. The women were randomly assigned to one of six 16-week treatments and were treated by one of two experienced psychiatrists. The posttreatment tests were the following: two self-rating scales, a global mood scale used by the treating psychiatrist, and a global mood scale and a scale measuring quality of relationship that was used by a person considered to be significant to the patient. A number of possible predictors of posttreatment test results were examined in a stepwise multiple regression. Eight measures were predictive of posttreatment test results at statistically significant levels. Four of these (an initial low level of distress; the use of imipramine; a good, fair or no employment history rather than a poor work history; and a positive attitude toward group therapy) were predictive of a good response regardless of the patient's treatment assignment. Two of the predictors were significant only for groups of women who received certain types of medication. For women who received diazepam, concurrent treatment with estrogen-type medication was significantly predictive of good response to treatment. For women receiving imipramine and diazepam, a low level of intelligence was significantly predictive of good response to treatment. Two predictors were significant for groups receiving specific types of therapy. Both less distress in the area of interpersonal sensitivity and a less positive attitude of a significant other toward psychiatric treatment were predictive of more progress for women receiving group therapy. The authors caution against drawing conclusions from their study regarding other populations of women. They point out that their sample is small and that it is difficult to generalize prediction evidence from one group to another.

213.

Deykin, Eva Y.; Jacobson, Shirley; Klerman, Gerald; and Solomon, Maida. The empty nest: Psychosocial aspects of conflict between depressed women and their grown children. *American Journal of Psychiatry*, **122(12):1422-1426, 1966.**

The authors report on their study of the empty nest syndrome—the "temporal association of clinical depression with the cessation of child rearing." A detailed schedule was used to obtain comparable factual, attitudinal and evaluative data on 16 hospitalized depressed patients. The data were collected from hospital records, nurses' and physicians' notes, and at least seven social work interviews with the patients and their families. Based on a narrative case summary, seven women were placed in an overt conflict category, and seven women were placed in a latent conflict category. Two women who were determined to be in the no-conflict category are not included in the study results. The authors report different demographic characteristics for the two groups of women, noting the most significant difference to be that five of the latent conflict patients were married and living with their husbands in contrast to only one of the overt conflict group. The overt conflict patients remained in the hospital for an average of 8.2 months in contrast to the 3.3 month stay of the latent conflict group. The 14 women shared a comparable degree of depression as well as a common inability to deal successfully with the termination of child rearing and to adjust to their status as childless mothers. In the overt conflict patient, the difficulty was characterized by violent and frequent arguments with her children. The underlying conflict concerned the patient's dissatisfaction with the amount and quality of emotional interaction she received from her children. The difficulty of the latent conflict patient was manifested in terms of a vague, undefined kind of dissatisfaction. This group had been fairly successful in satisfying their needs for emotional closeness by finding substitute objects in friends, work, or community activities. Dissatisfaction developed when they had to give up these substitutes because of their own or a family member's physical illness. They could not reconcile their intellectual acceptance of their children's independence with their own emotional needs for continued closeness. The family conference was the treatment approach used with the overt conflict patient. Therapy was geared to help the patient view and discuss the conflict in a more appropriate way and eventually to seek constructive ways of dealing with reality. Insight development was minimized with the latent conflict patient. The concentration was on reconstituting and reinforcing the successful adaptation these women had been able to make before the onset of depression. The authors conclude that the reestablishment of a healthy relationship depends largely on the careful diagnosis of the existing conflict, which in turn dictates the type of therapy to be undertaken.

214.

Miller, Paul R., and Ferone, Louise. Group psychotherapy with depressed women. *American Journal of Psychiatry*, 123(6):701-703, 1966.

The authors report on the group psychotherapy program for depressed women that was developed at the Mental Health Clinic of De Paul University in Chicago. The majority of applicants using the clinic service are from the lower social classes and have strong ties to national ethnic and religious groups. A social profile and psychiatric summary of the 14 women who were treated in group therapy is provided. The women had similar social backgrounds and psychiatric profiles, and most had sought help from numerous sources before coming to the clinic. Psychodynamic patterns and character structure were also similar. The presenting complaints included inability to manage the household, poor relationships with family, feelings of inadequacy and depression, and one or more realistic stresses which represented an object loss. In presenting the patient profile, the authors provide a summary of the object relations of the 14 women. The women are described as similar to the kind of patient Grinker and associates (1961) described in an inpatient setting. They were demanding, provocative, and hypochondriacal. They revealed cognitive disturbances, agitation, and thought confusion, and they had psychosomatic symptoms and made clinging appeals for love. In that group members placed one another in the roles of rejecting mother, preferred sibling, distant father, and so on, they had the opportunity to experience the "other side" of important relations. They were alternatively supportive and harshly realistic with one another. The group members were often in touch with one another outside of therapy and derived satisfaction from being supportive to another member who needed help. The authors indicate that the patients responded expressively in a group setting and revealed all the significant roles and feelings that they experienced in their lives. Although distortions of reality were prominent, they were responsive to the reality testing of other group members. The authors report two areas of evidence to support the contention that group therapy with depressed women works as well, and sometimes better than, individual therapy: (1) five patients needed to be hospitalized for psychiatric reasons before joining the group but none have been hospitalized subsequently; and (2) almost all had undergone individual therapy without sustained symptom relief, whereas they maintained their improvement in the group. Based on their experience the authors conclude that group psychotherapy with depressed women is a worthwhile effort.

215.

Mostow, E., and Newberry, P. Work role and depression in women: A comparison of workers and housewives in treatment. *American Journal of Orthopsychiatry*, 45(4):538-548, 1975.

This study investigated the impact of an outside work role on 42 female patients in a treatment program for depression. Twenty-one workers and 21 housewives, aged 25 to 60, were matched on age and marital status. The study deals with the first 3 months of active treatment, from acute illness to recovery. The subjects, who were all given antidepressant therapy, were interviewed to obtain social, demographic, and psychiatric information; they were assessed by psychiatrists for mental health status, and the Social Adjustment Scale was administered. There were no statistically significant differences in the sociodemographic characteristics or the psychiatric or social histories of the two groups. Although the group of workers were slightly more depressed at entry (Raskin mean score of 9.8 compared to 8.8 for housewives), after a month the difference was barely perceptible, and after 3 months the worker group was shown to be significantly less depressed ($p < .03$). A comparison of the two groups for social adjustment during acute illness showed that the housewives were significantly more impaired in their work role—they revealed impaired performance, lack of interest, and economic inadequacy. When the same factors were compared during recovery, the housewife group was still significantly more impaired in these same areas and in feelings of inadequacy. The authors suggest that working offered depressed women some distraction and protection that the housewives did not have. The working women felt more competent in their work, less bored in their free time, and more at ease in social situations. Most previous literature on this subject has dealt with well-educated, upper-class women who generally work out of choice; however, the women in this study came from the lower socioeconomic levels and worked out of necessity. In spite of this and the fact that their jobs seemed to hold little potential for gratification, working seemed to serve a protective function; workers were more interested in their work and felt more competent than the housewives. The study raised the problem of defining work for women, since most women, even those who work outside the home, generally retain the homemaker role. The authors feel that this study suggests other studies—studies to determine whether depression is less prevalent in women who work outside the home than in housewives, to determine if work serves as effective therapy for depression, and to compare depression in workers of both sexes. On the basis of their findings the authors suggest that women in treatment should be encouraged to maintain their jobs, despite impairment because their jobs may aid in their recovery.

216.

Padfield, Marianne. The comparative effects of two counseling approaches on the intensity of depression among rural women of low socioeconomic status. *Journal of Counseling Psychology*, 23(3):209-214, 1976.

Padfield reports on her investigation of the comparative effectiveness of two counseling procedures in treating depression. She initially notes that depressive disorders rank first as the cause for female admissions to psychiatric services in general hospitals in the United States. The subjects, who were moderately depressed rural women of low socioeconomic status, were seen in individual counseling sessions. The first of the two approaches involved building a relationship between the client and the counselor; only the dimension of responsiveness—made up of empathy, respect, and concreteness—was used, and the counselor relied heavily on reflective statements. The second approach added to the first a counselor-initiated course of action specifically developed for the treatment of depression. The following six components were included: (1) a 3-month time limit for counseling, following a 2-week diagnostic period; (2) home observation and coding verbal interaction when possible, to determine social-skill deficits; (3) daily mood ratings; (4) daily pleasant events tracking of activity level to find correlations between specific environmental events and mood fluctuation; (5) role playing to try new assertive, contingent behaviors; and (6) making the time that the patient and counselor spent together contingent upon the patient's achieving specified goals. Padfield hypothesized that women treated with the second approach would be less depressed at the end of treatment than the other women. Twenty-four women, who were recruited from a wide variety of sources (e.g., welfare, schools), were randomly assigned to one of the two experimental groups. All but one woman received the full set of posttests; she had moved but did complete some of the tests by mail. The following measures of depression were used: the Zung Self-Rating Depression Scale, Grinker Interview Checklist, the Pleasant Events Schedule, and self-reported daily mood tracking. Tape recordings of sessions were rated to verify that the two experimental approaches had actually been used, since one counselor had provided both types of therapy. Univariate analyses of variance revealed that the only measure of depression which significantly differentiated the two treatment groups was the Grinker Interview Checklist. The counseling model employing the general behavioral paradigm provided more improvement in intensity of depression, as had been hypothesized. The author notes that this finding was not supported by other measures of depression. An additional finding was that lower-class women improved more than working-class women. Padfield suggests that her study demonstrates that lower-class individuals can benefit from verbal therapy. She provides a discussion of the limitations of the study design.

217.

Weissman, Myrna M. Depressed women: Traditional and non-traditional therapies. In: Claghorn, James L., ed. *Successful Psychotherapy*. New York: Brunner/Mazel, 1976. pp. 170-188.

Weissman reviews the data on sex differences in rates and treatment of depressive disorders. She establishes that women more frequently report depressive symptoms than men, are diagnosed as depressed more often, and seek outpatient treatment for depression in even greater proportion. Additionally, she evaluates the effectiveness of ambulatory treatments for depression—pharmacotherapy and psychotherapy. Four controlled studies revealed that antidepressants reduce symptoms but have only limited impact on problems in living associated with depression. Indicating that no controlled clinical trials specifically devoted to the use of psychotherapy for the acute treatment of depression have been conducted, Weissman summarizes three studies on the maintenance treatment of depression with individual, group, and marital therapy. She indicates that there is no evidence that traditional forms of therapy do more than treat symptoms or prevent the recurrence of depression after treatment ends. Weissman points out that the value of traditional therapies is being challenged by feminists, who argue that the best prevention of depression lies in reducing the social conditions that depress women, and in their social retraining. The predominance of women among depressed patients is concluded to be at least partly due to women's social roles. Women actually are more helpless than men because of social inequities and the learned helplessness inherent in the stereotypical female role. The implied "treatment" for social inequities is political, legal, and social change on a societal level and the development of technical skills on a personal level. Treatment for learned helplessness involves the development of an emotional awareness of the condition, a raised consciousness, and the ability to function independently. Weissmann describes two different types of self-help groups and how they relate to the treatment of depression. The first group is an educational and counseling center for college-educated women, oriented toward improving their skills and making them less helpless. A third of the 100 consecutive center applicants were found to have mild to moderate depressive symptoms and were compared with a matched group of women in treatment at a depression research unit. Over the 4-month study period none of the counseling center women received psychiatric treatment or medication, but all of them had worked out career or educational plans and all were asymptomatic. Weissman suggests that women's self-help groups may include a number of women with preclinical or early depressive disorders and that the group, by helping these women overcome their feelings of helplessness and develop new skills, may have important implications for the prevention of depression. She goes on to compare the second identified self-help approach, the consciousness-raising group, with traditional psychotherapies.

Since women who have been involved in consciousness-raising groups have reported more independence, confidence, higher ambition, and a general sense of well-being, Weissman suggests that consciousness-raising groups may be good alternative sources for preventing depression in women. She concludes that traditional treatments fail to deal with the basic cause of depression and have achieved little in terms of prevention. Although hard data on the effectiveness of self-help groups as therapy are lacking, Weissman writes that they have an "intuitive appeal" for the treatment of learned helplessness and may prove valuable adjuncts to traditional therapy following symptom reduction.

218.

Weissman, Myrna M., and Paykel, Eugene S. ***The Depressed Woman: A Study of Social Relationships.*** **Chicago: The University of Chicago Press, 1974. 289 pp.**

As part of a larger study of maintenance treatment for depression, the authors assessed the social adjustment of 40 acutely depressed women patients over a 20-month period (8 months of treatment plus 1 year of followup). All patients received amitriptyline for 3 months; patients were then given either amitriptyline, placebo, or no medication (due to small sample sizes, drug comparisons are not reported). Half of the patients received weekly therapy with a woman social worker; the other half ("low-contact patients") received only symptom assessment sessions with a psychiatrist. Controls were 40 "normal neighbors" matched on demographic variables. Most subjects were white, married, working-class women; over half had Italian Catholic backgrounds. The 49-item Social Adjustment Scale, developed for this study from previous instruments, was used to assess social functioning in semistructured interviews conducted by research assistants. Normal neighbors were tested once and patients six times over the 20-month period. Additional data on the depressed patients were derived from narrative summaries and from ratings by psychiatrists and social workers on such indices as the Brief Psychiatric Rating Scale and Hamilton Self-Rating Depression Inventory. Six dimensions of social impairment were identified: work performance, interpersonal friction, emotional dependency, inhibited communication, family attachment, and anxious rumination. Patients' scores indicated more impairment than normals on 40 Social Adjustment Scale items, particularly in the areas of work, marital, and parental relationships; however, women working outside the home showed less impairment than housewives. Differences were less striking in areas of leisure activities and relationship with extended families. Social functioning tends to improve with symptom remission, but the improvement is slower; scores do not reach the level of those of normal control subjects. At 8 months, nonrelapsed patients given therapy functioned significantly better in terms of their social adjustment than low-contact patients and were closer to normals, although they were very impaired in social and leisure activities. Symptom remission was not correlated with psychotherapy contact. At 1-year followup, patients' functioning had shown still more improvement but continued to be worse than that of the "normal neighbors." The authors discuss possible problems related to methodology as well as implications for further research, and they include an appendix of evaluation instruments used in the study.

219.

Weissman, Myrna M.; Prusoff, Brigitte; and Pincus, Cynthia. Symptom patterns in depressed patients and depressed normals. *Journal of Nervous and Mental Disease*, **160(1):15-23, 1975.**

To assess the relationship between clinical and nonclinical depression, the authors investigated symptom patterns in two groups of women—depressed "normals" (clients at a university counseling center seeking educational-vocational help who were identified as having borderline to mild depression) and 18 clinically depressed women who were participants in an outpatient research study. Most women were under 30, white, and married; most depressed patients were Catholics, reflecting the population from which they were drawn. Subjects were matched on age, race, and marital status. Clinical symptom patterns were assessed by a modification of the Hamilton Rating Scale at initial interview and 4 months later. The Raskin Three Area Scale for Depression was also administered to assess mood, verbal report, and secondary symptoms of depression. The authors report that at initial testing, the rating of "sad feelings" was higher for depressed normals than patients; clinically depressed patients tended to be (nonsignificantly) more impaired on other items—feelings of guilt, pessimism, suicidal tendency, work and interests, energy, irritability, insomnia, retardation, depressed appearance, self-pity, hypochondriasis, hostility, or increased appetite—and significantly more impaired on measures of somatic complaints and somatic anxiety. At the 4-month rating, the depressed patient group had been receiving amitriptyline for at least 3 months. Only one "normal depressive" had been referred for treatment. Both groups improved, but the normals improved to a slightly lesser extent. There was a tendency for the normals to express slightly more depressed feelings, to be somewhat more slowed down (retardation), and to look depressed. The groups of depressed women were diffentiated by behavior, not mood. "Normals" felt as sad as patients but had significantly fewer symptoms of anxiety and its components. The authors point out that several questions are raised by this study: (1) Why did the unhappy "normals" seek vocational-educational rather than psychological counseling? (2) Are antidepressants indicated for depressive symptoms without the presence of the clinical syndrome? and (3) What would be the effect of antidepressants on "normals"? They identify the need for more work on the mild and most common forms of mood disorders to determine treatment indications and diagnostic signs.

Marriage/Divorce

220.

Anderson, Carol M.; Meisel, Susan S.; and Detre, Thomas P. "Sex Roles in Marriage and Marital Therapy." Paper presented at the 128th Annual Meeting of the American Psychiatric Association, Anaheim, Calif., May 5-9, 1975.

The desirability and actuality of co-equal responsibility in marriage was assessed in a sample of 50 couples in marital therapy and in 43 family therapists (28 female and 15 male). A questionnaire assessed subjects' opinions on how responsibility should be shared in eight major areas; subjects were then asked what was done in their marriages. Although most spouses endorsed sharing on all eight behaviors, responses indicate that such behaviors were not in fact shared. Less than half of the wives reported equality in caring for the home, having a career, caring for children, and being sexually aggressive. Only two thirds of husbands reported sharing of major decisions, mutual faithfulness, having interests that do not include the spouse, and joint financial decisions. There were significant differences in six areas for wives and in two areas for husbands on "should" versus "does" responses. Husbands and wives differed significantly on reports of who cares for children and home, with husbands seeing themselves as more active than wives did. The ideal of shared responsibility was also endorsed in the therapist sample, but therapists' "should" and "does" responses were different in four categories—child care, fidelity, home care, and sexual aggressiveness. The authors indicate that such differences in ideal and actual behavior can cause strain in marriages that must be recognized and dealt with effectively by family therapists, noting that the therapists' discrepancies on ideal versus actual sharing may lead to bias in the therapeutic interaction. They recommend that therapists help couples to integrate changing sociocultural patterns into their marriages and to develop individual models of role behavior rather than traditional or standardized models. Additionally, couples who disagree in various areas should be made aware that they have options in sharing responsibilities.

221.

Aslin, Alice L. Counseling "single-again" (divorced and widowed) women. ***The Counseling Psychologist*****, 6(2):37-41, 1976.**

Aslin theorizes that divorce and widowhood are traumatic for women because their usual ways of coping become inappropriate. Their socialization to obtain identity from the passive wife and mother roles and to subjugate themselves to the needs of others has not prepared them to function as unmarried individuals, as autonomous adults. Counseling psychologists working with divorced and widowed women are advised to recognize this trauma and to be aware of the multiple implications of the separating process and the numerous areas in which women may be unprepared to live as single persons. Reference is made to Bohannan (1970), who suggested that there are at least six processes occurring when a women is divorced or widowed—emotional, legal, economic, parental, community or social, and psychic. Aslin indicates that by focusing on any one or a combination of these six areas, the counselor assists the single-again woman to work through the trauma of losing her wife identity and to begin to cope autonomously. Each of these processes is discussed, and a table is provided which summarizes the stereotypic wife behavior, the disorganization experienced by the woman as she loses her role, her counseling needs, and her autonomous single-again role for each of the six indentified processes. The following are identified as the counseling needs of the single-again woman: to be in touch with others (women's groups) in order to achieve a sense of personal emotional identity, assertiveness training and support to obtain needed legal information, guidance to aid her children in their adjustments, help for the divorced woman in developing a workable relationship with the children's father and paternal family, assistance in understanding others' reactions to her in her new role as a single woman and in dealing with options for new relationships, and, finally, help to work through her grief and develop a new life. Aslin suggests that when dealing with this problem area counselors need to attend to the potential influence of their own attitudes, training, and feelings about a single woman's struggle for autonomy and their own marital status on the growth process of a single-again woman. In concluding Aslin reports that one approach for dealing with the problems of the single-again woman has been the development of specific programs, which range from women's groups and divorced women's workshops to career planning, legal information, and financial management programs. Aslin indicates that such workshops tend to be most effective the more homogeneous the group. She suggests that to achieve homogeneity workshops can concentrate on particular populations within the single-again group.

222.

Bach, George R. Creative exits: Flight therapy for divorcees. In: Franks, Violet, and Burtle, Vasanti, eds. *Women in Therapy: New Psychotherapies for a Changing Society*. New York: Brunner/Mazel, 1974. pp. 307-325.

Although divorce is an inherently traumatic experience, the cultural changes of the last 30 years are enabling psychotherapists to help make divorce a growth-inducing process. Now that women identify themselves as potentially independent and whole persons a divorce can be the first step toward freedom and self-development. Growth and gains can be made immediately through the many opportunities for "aggressive self-assertion" that exist in the divorce process. A woman can take control of her own divorce rather than allow others to handle things for her. Exercises have been developed to overcome the "aggression phobia" that exists in this culture. Women must learn to act in a new self-assertive way and to abandon false ideals of "femininity." Exit fighting training was given to teach couples to fight fairly. This allows for learning and minimizes the bitterness often aroused by the vicious fighting that can occur at this time. A stylized "unwedding ritual" was used with 52 participants giving them the opportunity to deal thoughtfully and seriously with what divorce means and how it would better their lives. Four years later 33 of the participants continued to feel that this ceremony had been helpful to their growth. Exit exercises are provided to ward off the panic and possible violence of leaving a partner.

223.

Carter, Dianne K. Counseling divorced women. ***Personnel and Guidance Journal*****, 55(9):537-541, 1977.**

Presenting divorce as an especially severe crisis for women, Carter discusses what kinds of counseling are most effective with divorced women and her own counseling efforts with this group. After comparing all-women's groups with mixed-sex groups and individual counseling, Carter concludes that the all-women therapy group is most effective because (1) it is an alternative to the traditional model in which a woman is encouraged to focus all her dependency needs on one other person and (2) it teaches women that they can receive support and protection from other women. By sharing experiences and feelings, women come to distinguish problems that are their own responsibility from those that are culturally produced. Carter notes that a female counselor has the advantage of being able to function as a role model and that, in addition, there are several reasons why men should not lead all-women therapy groups or provide individual counseling to women experiencing divorce crisis. Pointing out that many women have never had to be on their own before their divorces, Carter discusses three treatment goals designed to help women become independently functioning adults: achieving autonomy and financial independence and countering loneliness. She goes on to describe in detail the treatment approach she developed over a 2-year period of working with divorced women of varying backgrounds in a university setting. The counseling format consists of two ongoing groups meeting for a 6- to 8-week period, one for newly divorced women who require much support and individual attention and the other for women who have been divorced for 2 or more years or have been transferred from the first group. Carter begins therapy by clearly stating her feminist values and by telling of her own marriage and divorce. She reports that her self-introduction reduces tension and provides a model for group participation. The most important treatment element in these groups is identified as the sharing that occurs among the women. In addition to facilitating an open and supportive atmosphere, Carter uses three interventions that she considers to have the most impact: (1) To process emotions, role playing, gestalt techniques, and creative fantasy are used. (2) Contracts are used in a problem-solving phase that follows emotional processing and the determining of goals. (3) Cognitive restructuring is used to counter negative and self-defeating feelings. All three phases of treatment are explained fully. Carter concludes by suggesting that divorce can be an experience that leaves a woman "more whole" and strengthens her. She contends that the direction of a woman's growth will reflect what her counselor feels is possible and appropriate for women.

224.

Dries, Robert Michael. The divorced woman: Measurement of self-actualization change and self-concept. (Abstract source, *Dissertation Abstracts International*, 36(B):884, 1975.) *Dissertation Abstracts International.* Ann Arbor, Mich.: University Microfilms, No. 75-18046. 187 pp.

In this study Dries attempts to measure positive changes in middle-class divorced women who belonged to a divorce adjustment organization. Participants were 128 middle-class, urban, white divorced women between the ages of 22 and 55. The experimental group consisted of 103 new members of the We Care organization in San Diego, a group established to help women cope with the problem of divorce adjustment. Twenty-five divorced women who were similar to the experimental group members in important demographic variables but were not members of a divorce organization served as controls. The Personal Orientation Inventory was used to test all the subjects and then to retest them 1 to 8 weeks later. Following the retest, 22 women agreed to attend an academic class on Creative Adjustment to Divorce taught by the experimenter in addition to their participation in weekly We Care meetings. The We Care members, the We Care members attending the academic class, and the comparison group all had comparable mean scores on the POI retest. After a 10-week period, the women were tested again with the POI and with the Tennessee Self-Concept Scale. Data analysis revealed that mean group scores on all scales of the two measures were in the normal range for each of the three groups. No significant difference was noted between the experimental group (We Care) and the comparison group POI mean scores following a period from 1 to 8 weeks. Over a cumulative period of 11 to 18 weeks, a significant difference was noted between the regular We Care members, the We Care members attending the class, and the comparison group. Additionally, members attending the academic class revealed a significantly greater amount of change over the 11- to 18-week period when compared to the regular We Care members. Thus, Dries concludes that a divorce adjustment organization was instrumental in promoting divorce adjustment among women participants and that an academic class on the subject of divorce adjustment was helpful in promoting even greater adjustment. He adds that the two experimental groups showed positive change, scoring in the self-actualizing range, and suggests that some divorced women use the divorce experience to creatively adjust.

225.

Gingras-Baker, Sylvia. Sex role stereotyping and marriage counseling. *Journal of Marriage and Family Counseling,* **2(4):355-366, 1976.**

The premise of this article is that sex-role stereotyping is a critical factor in marriage counseling. The negative valuation reflected in the female stereotype makes sex-role stereotyping especially destructive. Since the consequences of this stereotyping are played out on their most intimate level in marriage, the author suggests that marriage counselors should be aware of sex-role stereotyping and how it may effect their clinical judgment. The literature is reviewed and the 1970 Broverman et al. study is cited on the pervasiveness of sex bias in the treatment of women by mental health professionals. More recent data are examined to determine whether changing sex roles have altered clinicians' biases, and the author concludes that the later studies indicate that sex-role stereotypes with a negative valuation of women continue to distort clinical judgment to the detriment of female clients. The consequences for women of sex bias, are discussed. This bias is said to permeate social science research in theoretical as well as in methodological issues—a serious problem because of academicians' influence on counselors who use their research as reference material. Alternative approaches to family studies and sex-role research are presented, and suggestions are made as to how marriage counselors can deal with the bias in the research. The implications of recent research on sex-role stereotyping for marriage counselors are discussed. The author suggests that marriage counselors need to involve themselves in consciousness raising. The new awareness they would gain about their own sex-role stereotyping and sex bias would enable them to reassess their values and monitor their imposition on clients. Both the cognitive and affective levels of consciousness raising are discussed. Since recent research demands that marriage counselors be open about their values and bias and adopt an egalitarian role, the author recommends courses and workshops in treatment approaches consistent with this egalitarianism in addition to consciousness raising. She states that counselors must also be aware of the influence their sex may have on treatment. Male-female co-therapy teams are identified as an important innovation in counseling, but these teams must be careful not to reinforce the traditional male-female role model. Marriage counselors can help couples bring their covert role conflicts to the surface and deal with them effectively, and they can also bring an awareness of alternative life styles to their practice. In concluding, Gingras-Baker recommends that the American Association of Marriage and Family Counselors establish a task force to examine its role in society in relation to sex bias and sex-role stereotyping, and she proposes specific activities for this task force.

226.

Resnick, Jaquelyn Liss, and Dewey, Cindy Rice. A developmental approach to marriage counseling. *Voices*, 12(3):63-66, 1976.

A three-stage developmental model for marriage counseling with women, both as a conceptual formulation and a service orientation, is proposed. The authors report that more and more women are experiencing difficulty with some aspect of their marital relationships. They discuss the problems of the traditional marriage, pointing out that a woman's difficulties in her relationships with men are often related to societal pressures to fulfill the feminine stereotype. The result is conflict for many women who are trying to resolve the discrepancy between their image of how they "should" be and their real selves. The identified goal of the authors' Women's Walk-In Counseling Service is for women to choose and create alternatives for living that exceed the traditional norms and boundaries of sex roles. Since women appear to experience marital problems along a continuum, the authors suggest that intervention not be limited to counseling with husbands present. Although many women come to the counseling service alone, the women's concern is still directly related to their marriages. The pre-dyadic, dyadic (husband present), and post-dyadic stages of the authors' developmental model for marriage counseling are described, and quotes from the counselees are included. Counseling at the pre-dyadic stage focuses on clarifying the woman's feelings and helping her to find the source of her problems and to develop a new sense of self. Support for change in lifestyle is offered. Resolution of this stage may lead to dyadic counseling, in which attention is placed on the couple's relationship—clarifying the process of interpersonal relating and developing effective communication skills. New roles and new interpersonal relating or separation and divorce may be the result. In the post-dyadic stage, women alone (separated, divorced, widowed) are helped to define themselves after marriage. The task is the development of viable future goals. Small groups are identified as particularly appropriate for providing a supportive environment for women in transition, and assertiveness training is considered as potentially helpful. Support is provided, and life without a man is presented as an alternative lifestyle rather than a stigma to be changed.

227.

Rice, David G., and Rice, Joy K. Non-sexist "marital" therapy. *Journal of Marriage and Family Counseling*, 3(1):3-10, 1977.

The authors focus on marital therapy for the increasing number of couples seeking to evaluate and restructure their marriages. Traditional marriage is defined and then contrasted with egalitarian marriage, in which all responsibilities are shared and contributions are based on individual preference and capacity rather than on sex-role conditioning. Three primary factors are suggested as limiting therapist effectiveness with people who are in conflict about or disenchanted with traditional marriage: (1) the gender and sex-role conditioning of the therapist; (2) the effect of socially reinforced sex-role stereotypes; and (3) the therapist's own marital situation and/or experience. It is felt, however, that once therapists become aware of their difficulties in coping with the idea of nontraditional marriage, they can maximize their effectiveness in work with clients troubled by traditional marriages. The authors discuss three general types of such experiences and their treatment implications: working with a co-therapist of the opposite sex, becoming open to alternative lifestyles, and using some specific therapeutic marital tasks and procedures. Working with a co-therapist of the opposite sex can be a powerful learning experience for the therapist and an effective interpersonal modeling experience for the patients. The authors caution, however, that co-therapists need to function as equals and not reinforce traditional patterns of male-female relating. Changing their own marital relationship is considered the most direct way to become open to alternative marital lifestyles. It is especially important for therapists to reexamine their attitudes and biases about divorce if they are to be open to nontraditional marital lifestyles. Divorce and separation must not be equated with therapeutic failure if couples who choose to end their marriages are to be helped. Rice and Rice report that certain tasks and procedures have proven effective in helping couples restructure their relationships toward a more equalized sharing of overt, socially recognized power. They base their work on the hypothesis that sharing of this power leads to enhanced self-esteem and promotes personal growth in both partners; they also maintain that social, economic, and political determinants must be given equal weight with intrapsychic considerations in treating marital dysfunction. The following techniques have proved helpful in their work: (1) actively working with the couple to establish a division of labor schedule that delineates sharing of household tasks; (2) exploring and spelling out the marital contrast especially in terms of sex-role expectations and behaviors; and (3) arranging a structured separation experience with counseling and reinforcing an open companionship model for each partner. A case study is included to illustrate the use of these therapeutic techniques. Rice and Rice conclude that this kind of therapy can free men and women from stereotyped patterns and help them form new kinds of interpersonal bonds that offer possibilities for greater personal and conjoint growth.

228.

Seidler-Feller, Doreen. Process and power in couples psychotherapy: A feminist view. *Voices*, 12(3):67-71, 1976.

Feminist therapy is defined as treatment that uses a social causation model in understanding human dysfunction. A belief in the unequal distribution of social power is central to the feminist critique of society, and power redistribution is considered a goal of therapy. Suggesting that feminist therapists have unsophisticated conceptions of power, Seidler-Feller briefly discusses the distinct types of power people use in various influence situations—expert, legitimate, informational, coercive, reward, and referent. Giving serious attention to the kinds of power bases men and women use adds an important dimension to a process-centered view of feminist therapy. A central assumption of the author's work with couples is that their power and resources have not been amply used either individually or collectively. This is exhibited in the couple's desire to surrender themselves to the therapist's expertise. The therapist combats dependency by refusing to use expert and legitimate means of influencing clients and by diminishing the authority they attribute to her. Throughout therapy, reliance is only on reward, informational, and referent power, so that behavior consistent with the goals clients stated in their contract is reinforced. The author asserts that feminist therapy requires that the process "concretize and reflect feminist sentiment"; this demands that informational and referent power predominate in the therapist's relationship to her clients. Within the client system, research indicates that decision areas of married life are sex-typed and that men and women display different forms of power. Socialization teaches women to deny themselves certain types of power and competence, and this sex-stereotyped functioning accounts for the low self-esteem they exhibited. The author begins therapy by commenting on clients' stereotypical power displays and their effects. If this proves useful, her next step is to demonstrate other modes of influence and their effects. As work progresses, the clients come to have more knowledge about power and the value of stereotypical modes diminishes. They begin to recognize what forms of influence are most desirable in specific situations. The author discusses how power preference analysis, which focuses on the different access to power society provides for men and women, accomplishes several ends that are consonant with mental health. Women are taught to use power in ways congruent with their needs and resources, and they learn that a whole range of power possibilities is available to them. Men learn to use other softer modes of power, previously confined to women, and are helped to better understand their interactions. Acknowledging that power behavior does not explain all psychological behavior, the author concludes that it is a useful focus in therapy, since the therapist is in an influence situation and couples make many attempts to influence each other in everyday life.

229.

Perlman, Caryle, and Givelber, Frances. "Women's issues" in couples treatment—The view of the female therapist. ***Psychiatric Opinion*****, 13(1):6-12, 1976.**

Two therapists discuss the "women's issues" that emerge in couples therapy and their perceptions of the opportunities and countertransference problems encountered in dealing with them. Couples continue to seek therapy to deal with traditional problems in their relationship, but the theme of woman's changing status now runs through most treatment. Women's self-concept is changing. When a woman changes her self-definition to a more liberated concept and her husband does not, conflict may result. Spiegel's concepts of role induction and role modification—the two major kinds of conflict resolution—are presented and defined. The therapist's role is to help couples whose coping mechanisms have failed them. The sources of this failure must be identified and new problem-solving skills, which will result in role modification, must be learned. Role modification is the more stable form of conflict resolution, since it is arrived at through mutual exploration and compromise. The therapist begins by assessing the strengths and weaknesses of the couple's relationship and by examining with both partners what caused the current distress. The authors believe it is important to explore how couples experience and deal with role conflicts brought on by the women's movement. Case histories are presented to illustrate the different ways in which these issues emerge and how their true significance can be masked. Female therapists working with couples are felt to have several advantages: (1) the couples are more likely to form an alliance with the therapist and acknowledge their own problem-solving resources, since women are perceived as less powerful than men; (2) women therapists are less threatening to couples; (3) men seem to be more willing to express their vulnerability to women, and this is often important in a relationship where roles have polarized; and (4) women therapists can also be more effective in modeling for couples, showing in themselves the possibility of combining personal traits thought of as divided between the sexes and also showing the possibility for combining roles of professional, wife, and mother. This presentation of what liberation could be may abate fear and open up alternatives to traditional roles. The authors believe it is vital that couple's therapists not be locked in traditional roles. They feel that as women they have particular sensitivity to role conflict. Two case histories are provided to show how couples can be helped to discover alternatives to traditional roles. Countertransference is seen as presenting a particular problem in this therapy because: (1) the issues dealt with are very close to the woman therapist's own life and (2) women's issues are so new therapists may not themselves have worked the issues through as thoroughly as they have older conflicts. Special effort must be made by therapists to keep their own conflicts from influencing their work. The authors conclude that it is crucial to recognize the full range of possible solutions for each individual and couple.

230.

Wolman, Richard N. "Women's issues" in couples treatment—The view of the male therapist. ***Psychiatric Opinion*****, 13(1):13-17, 1976.**

Wolman identifies the women's liberation movement as one of the most significant psychosocial developments of this century. It has brought about a new consciousness in women of their personal worth as well as a reassessment of their goals and lifestyles. Consequently, it has often produced conflict and anxiety that affects men as well as women. The women's revolution is recognized as having had profound effects on the practice of psychotherapy. Women are challenging the basic assumptions of psychotherapy and have helped to change its orientation from the medical model of symptom relief to a more psychological model of growth and development. Wolman believes this revolution has been especially helpful to the psychotherapy of married couples. It has created a psychosocial climate that promotes discussion by couples of basic issues and gives them expectations of growth and change. Often, women no longer have to be helped in establishing their self-esteem before real couple therapy can begin. Wolman now includes a female co-therapist in his treatment of couples; in this way, he avoids destorted perceptions that may arise from his male orientation. The use of co-therapists also provides for possibilities of multiple transferences that are not available with just one therapist. Additionally, it neutralizes defensiveness women may have about male therapists and helps couples learn to relate honestly to both sexes. Women who have been influenced by the movement are identified as better patients who enhance psychotherapy by their willingness to deal with basic and highly sensitive issues. Therapists must, however, be aware of the possibility of the new ideology being used defensively to avoid dealing with more painful issues. Although the total effect of the women's revolution on psychotherapy and psychotherapists cannot yet be assessed, Wolman believes it has added depth and dimension to the process, especially for work done with couples, by promoting a reevaluation of the basic principles of psychotherapy and of the psychotherapist's personal values and attitudes.

Motherhood/Mothering

231.

Andrews, Ernest E. Some group dynamics in therapy groups of mothers. *International Journal of Group Psychotherapy*, 12(4):476-491, 1962.

Use of the group approach with mothers whose children are in treatment at a child guidance clinic is described. Seven or eight mothers meet for 90 minutes once a week. The mothers selected for these groups are considered to have neurotic or characterological patterns that figure significantly in their relationships with children.

The objective of therapy is a reconstruction or dissolution of the pathological patterns of the mother's personality that are dominant in her relationship with the child. The therapist uses basic elements of psychotherapy as elaborated by Slavson (1960)—transference, catharsis, insight, reality testing, and sublimation. In this type of therapy, certain group dynamics appear to arise out of the therapist's structuring of the group and the members' interactions. These are not the group dynamics of the group dynamicists, such as role diffusion, but are dynamics specific to the therapeutic functioning of the mothers' groups. Group dynamics are defined as the forces that produce effective action in a field. In this case, the field is the group of mothers, and the effective action is the elements of psychotherapy already identified. The goup is the vehicle of treatment for its individual members, with the dynamics acting as a facilitating agent for effective therapy. Operational definitions and clinical examples are given for each of the identified dynamics: group balance, group task orientation, universalization, extensive emotional support, extensive defense confrontation, and experiential validation. Additionally, the author discusses how each dynamic facilitates the therapy with mothers as well as the therapist's role in using the dynamics.

232.

Baum, Carolyn. Brief group therapy for single mothers: Some observations by a paraprofessional. *American Journal of Orthopsychiatry*, **44(2):214-215, 1974.**

In a short presentation, Baum discusses the problems experienced by single mothers with young children and describes a brief service group therapy program which was created to help them. Repeated clinical contact with single mothers of young children (who were generally white and middle class) revealed certain recurrent stresses and complaints. Thus, it appeared that this segment of the parent population was dealing with problems and anxieties specific to or exaggerated by their situation. The young woman with children experiences an identity crisis following her divorce or separation. Her previous position of emotional and economic dependence has changed to that of sole head of her household, and her identity and gratification, once closely associated with the identity of her husband and children, now require major reorganization. Additionally, she must deal with the separation anxiety of her young children. Baum reports that brief service group therapy frequently is effective in interrupting the cycle of despair that the single mothers experience. Group members who have reentered the working world and begun to explore an autonomous identity provide an influential model for those women who have not yet succeeded in making a new beginning. Psychodynamics and the single mother's social predicament are explored in the group meetings. A nurturing environment usually evolves which seems to provide some substitute for the familial and/or institutional support that is essentially missing in the culture. During the course of just six 2-hour weekly meetings, growth as more independent, creative individuals becomes apparent in many of these women.

233.

Bellucci, Matilda T. Group treatment of mothers in child protection cases. ***Child Welfare***, **51(2):110-116, 1972.**

Ongoing weekly group therapy provided by a male-female team to 10 very deprived women who had neglected their large families is described. The mothers' participation in the group was mandatory as part of a plan to help the families function better together, thereby avoiding placement. Reasons for the intervention and expectations were made clear to each family. As the original intention was to develop a project, rather than simply group treatment, Bellucci describes the efforts to use available community resources and the benefits gained from additional funds, a summer program for the children, and homemaker service. She writes that the women shared similar problems and that the group, which was spontaneous from its first meetings, jelled quickly. Competitive feelings were evident after the addition of new and verbal members, resulting in feelings of withdrawal and loss. The group had become strong enough to demand commitment from those who act out by absences. Although the group members' positive support of one another has been strong, their negative reactions have encouraged each other's denial and fed their collusion. Breaking through these obstacles has been a major therapeutic task. Profiles of the 10 mothers and their families are provided. Focusing on the group dynamics, Bellucci identifies three problem areas and responses: (1) feelings of worthlessness, accompanying self-destructiveness, and pervasive distrust; (2) fear of their frequently overwhelming anger, with depressive overtones and the need for symbiotic relationships with their children to avoid these feelings; and (3) the use of marriages and early as well as frequent pregnancies to find fulfillment. The group process has been helpful as the group members seek out relationships. The group has both supported and confronted group members as they deal with their destructive and masochistic relationships with their own and extended families. The author cites the advantages of co-therapy and discusses the gains the women have made as a result of the group treatment. Their self-esteem is enhanced and, consequently they are better able to assert themselves. The married women have become better able to act to change or sever destructive marital relationships. Their image of men has changed as have their relationships with significant men. They can now relate on a nonsexual level. Finally, to some degree, the mothers are becoming able to accept acceptance, to be given to, and to begin to express anger appropriately without fear of rejection. The author concludes that more needs to be accomplished, including the ability on the part of the mothers to individualize themselves and their children. Those involved with this group method consider it worthwhile and effective but would like to find a shorter and less demanding method.

234.

Biller, Henry B., and Smith, Alice E. An AFDC mothers group: An exploratory effort in community mental health. ***The Family Coordinator*****, 21(3):287-290, 1972.**

An exploratory approach to working with a group of mothers supported by welfare is described. Twenty mostly young women who were separated or divorced, had small children, and received Aid to Families with Dependent Children met over a 1½-year period with two social workers and a psychologist. The group's initial goals focused on homemaking and personal appearance since these behaviors could be readily improved. A second goal was to increase the group's ability to become involved in the community and in constructive social action. A transition period is identified in which the mothers expressed much concern about family conflicts, particularly problems with their children. At the request of the group members, relevant professionals from other agencies led sessions dealing with child rearing. As a result, several mothers previously unwilling to seek out certain types of professional help were able to contact the appropriate agencies. The group leaders attempted to function as accessible role models and, to this end, tried to decrease interpersonal distance between themselves and the mothers. In discussing the group process, the authors provide a chronological review of content areas to indicate group movement and change in focus. Related to the increased awareness of their own feelings and conflicts that the women were acquiring was the ability to take the perspective of their children and other group members. They dealt with interpersonal relations within the group as well as with interactions with community agents. Other indications of change were the decreasing need of the group members to lean on the agency and their increased self-reliance. As a group, the mothers seemed to exhibit less socially disruptive behavior, and several mothers who had been chronically unemployed were able to find relatively permanent employment. The group did develop some ability to work with the community, and there were instances of community involvement (e.g., group-sponsored parties, dances, and bake sales). The authors conclude that there were improvements in the group members' functioning, including personal appearance, degree of group participation, and overall social adjustment.

235.

Bryant, Brenda, and Waterman, Jill. Factors relevant to treatment assignment of mothers seeking therapy. ***International Mental Health Research Newsletter*, 17(2):10-12, 1975.**

The authors indicate that mothers usually seek therapy because of conflicts about whether to focus on their own personal development or that of their children. They note that most recommendations about how therapy can better serve these women are simplistic and focus on the sex of the therapist. Data are presented to show that these recommendations are of little value, since both male and female clinicians appear to share sex stereotypes. The authors suggest that the psychotherapeutic system used by the therapist must be taken into account; if mothers are to be best served by psychotherapy, their values and conflicts need to be interfaced with appropriate therapeutic systems. They indicate that traditional values identifying woman's primary responsibility as nurturing the development of others are supported by psychoanalytic theory. Psychoanalytic theory places women in a bind by telling them simultaneously that they are incapable and yet fully responsible for their children's development. Three alternative types of therapeutic systems that regard woman's primary responsibility to be her own personal development are briefly described. These are consciousness-raising groups, behavior therapy, and rational-emotive therapy. The authors point out the possibility of striking a balance between self-actualization and family orientation and report that studies indicate that this is what many women would prefer. Existential conceptualizations of psychotherapy are considered consistent with this desire to find a balance between activity as stressed by the behavioral therapies and passivity as stressed by psychoanalysis. In existential terms, the conflict between personal growth and family responsibility is the essence of the human dilemma. Freedom lies in experiencing this conflict and taking responsibility for one's own being. Existential therapies help mothers to examine role conflicts without making value judgments. They focus on experiencing dilemmas and making choices. Since different schools of therapy have varying concepts of woman's proper role, the authors suggest that the values communicated to mothers in therapy have more to do with theoretical orientation than sex of therapist. Consequently, differences in orientation should be taken into account when recommendations for treatment are made. In conclusion, they suggest that (1) mothers who seek treatment should be made aware of their options and the differences in value orientations of the available treatment; (2) therapists need to assess themselves and be clear about the values they bring to their therapeutic encounters with women; and (3) both therapists and clients need to consider if and how the sex of the therapist is important in this particular therapy.

236.

Cyrus, Ada Shew. Group treatment of ten disadvantaged mothers. *Social Casework*, 48(2):80-84, 1967.

The group treatment of 10 Negro mothers supported by Aid to Families With Dependent Children is described. The women ranged in age from 25 to 39; their educational level varied from eighth grade to 1 year of college; they had from two to six children; they lacked vocational skills or training; and, for the most part, they had experienced maternal and emotional deprivation in their own primary family groups. Treatment goals were individualized, depending on the particular personality problems that impaired each woman's social functioning. Three illustrations of the diagnostic assessment and treatment goals outlined for each member are provided. The author recalls that initially the women were unable to express their feelings. To deal with this, she demonstrated her own feeling for them. In this way, the women began to feel freer to express their emotions and also became confident that expression of feelings can be controlled and can relieve inner tensions. In her work with the group, Cyrus needed to provide nurturance and recognition to each member individually while helping the group actively involve itself in each member's problems; she had to offer specific information as well as support and recognition of group members' slightest efforts to change or modify attitudes or patterns; and she served as a model on which the mothers might pattern their own behavior and manner of interaction with each other and their children. Because of similarity in life situations and problems, the women identified with one another quickly and revealed their feelings of deprivation, isolation, and loneliness. As the women became more comfortable about expressing and revealing themselves, further assessment of their usual mode of interaction in the situations contributing to their social difficulties was possible. Cyrus focuses on the sources of these social difficulties and her efforts to help the women develop healthy attitudes and the ability to communicate constructive and positive attitudes to their children. Providing examples of the accomplishments of some members, Cyrus indicates that gradually the women developed a sense of self and began to consider ways of improving their status. In concluding, she reports her belief that some degree of success was achieved with most of the mothers. They gained a sense of self, an improved self-image, and recognition and strength from one another. They were able to resolve some of their conflicted feelings about authority figures and achieved some understanding of the effects of unresolved conflicts on their current life situations and interactions with their children. The mothers became more aware of their need to understand and to listen to their children in order to become more effective in dealing with them. Direct contact with other women who had similar problems reduced their sense of social isolation.

237.

Fowler, D.B., and Brandon, R.E. A psychiatric mother and baby unit. *Lancet*, 1(7377):160-161, 1965.

The authors briefly report on the effectiveness of a mother and baby unit. During a 2-year period, 34 patients (17 schizophrenics, 10 women with puerperal depression, and 7 with neurotic breakdown in the puerperium) were admitted to a 20-bed villa catering to female acute psychiatric cases. Six of the patients had been hospitalized for a psychiatric episode before the pregnancy. Otherwise, the first signs of psychiatric breakdown appeared in the last weeks of pregnancy or in the first 2 months of the puerperium. The average length of stay for the patients was 48 days compared with 44 days for the other patients in the villa and 75 days for patients admitted without their infants. Treatment included electroconvulsive therapy, phenothiazines and thymoleptics, abreactive techniques, and supportive psychotherapy. The only difference from the customary approach was the continued presence of the infant and the patient's graded responsibility for it, along with the need to adjust to the social and domestic requirements of a self-contained and self-supporting unit. The authors suggest that the last two factors have been primarily responsible for the more rapid response which the patients have generally shown. Even the majority of the most acutely disturbed patients have accepted responsibility for their infants, under supervision, within 10 days of admission. This has avoided the decline in mothering attitudes caused by prolonged separation and provided the opportunity for the nursing staff to correct any deficiencies in the mother's knowledge of infant care. The mother is discharged first and given the opportunity to readjust to the home environment without responsibility for the child. As she becomes more stable, her child is discharged home. The patients are followed up at the outpatient clinic, visited at home by mental health officers, and immediately readmitted with their infants if necessary. Most of the 10 readmissions which occurred without further pregnancy were associated with marital disharmony and a failure on the part of family members, particularly the patient's mother, to allow the woman to adjust to life with her husband without undue interference.

238.

Grunebaum, Henry U., and Weiss, Justin L. Psychotic mothers and their children: Joint admission to an adult psychiatric hospital. *American Journal of Psychiatry*, **119(10):927-933, 1963.**

This article reports on 12 joint admissions of mothers with severe emotional disturbance and their young children (ages 1 to 18 months) to the adult wards at the Massachusetts Mental Health Center. Case summaries are presented for three of these admissions. The authors state that the attitudes of ward personnel are the most important consideration in making a joint admission, since they will be vital to the course the hospitalization takes. The authors believe that a joint admission will usually prove successful if the following steps have been taken: (1) there has been a careful preliminary evaluation of the mother and the nature of her illness; (2) a working relationship has been established with the woman's physician and the ward staff before the child is admitted; (3) the decision to admit the child has been made mutually by the staff, the patient, and her family; and (4) adequte provision is made for the physical needs of the child on the ward. Responding to the objections that have been raised concerning joint admission programs, the authors report that these 12 cases have not been disruptive to the ward, that there have been no instances of physical harm or overt evidence of psychological harm to the child, and that caring for the child has not been detrimental to the mother's therapeutic needs. The authors indicate that psychotic reactions in the postpartum period do not comprise a single clinical entity. On the basis of their clinical assessment of these first 12 cases, the authors suggest that the women may be divided into three overlapping groups. The first group of women had been reasonably successful in their prepsychotic adjustment. They had conflicts about their femininity, but psychosis did not develop until after the birth of the child. At this time, the mother expressed guilt over her inability to love the child. For these women, caring for a child in the hospital relieves their guilt about abdicating responsibility and allows them to develop positive feelings in a neutral and supportive atmosphere. Joint admission is considered to be particularly useful in this situation, because it allows the patient and treatment to focus on problems central to the illness. The second group of women, while expressing difficulty in caring for their children, really suffer from illnesses related to their marital relationship. Joint admission may help these women maintain their self-esteem, but it is not central to helping them solve their problems. The third group of women come to the hospital with histories of chronic depression and psychotic periods. The authors report that joint admission has not worked out well with these women. A final common objection against hospitalizing mothers with their children is the effect the mother's psychotic illness will have on the child's emotional development. The authors acknowledge that the long-term effects of this are not known. They raise several questions about the relationship between psychosis and mothering and the merits of the alternatives to joint admission. Based on their experience, the authors conclude that joint admissions are practical in certain cases and can contribute substantially to the mother's recovery.

239.

Kolodny, Ralph L., and Reilly, Willow V. Group work with today's unmarried mother. *Social Casework*, **53(10):613-622, 1972.**

Kolodny and Reilly begin their discussion by noting how the changes in mores have affected social work intervention with unmarried mothers. The authors identify the need for staff to discuss and analyze these changes so that confusion about the real problems of unmarried mothers can be avoided. They suggest that all that is certain is that unwed pregnancies bring young women with various problems to social agencies. All unmarried mothers require emotional support and can be better served by treatment that continues after the birth of the child. The authors point out that most group efforts directed toward unmarried mothers tend to concentrate on narrowly defined areas of need. They consider a more open-ended approach to be valuable, because it establishes meaningful contact that offers support and insight. Retaining contact after delivery is regarded as vital, for it is in this period that the woman's problems are likely to be exacerbated. The remainder of the article is in support of this position. Observations are presented on the group therapy of eight unmarried pregnant welfare recipients, ages 17 to 24, who had decided to keep their children. All the clients were also seen by a caseworker throughout the period of the group experience. The authors report on the early meetings of the group, noting the emotional support the members provided for each other. The group sharing that occurred was facilitated by pregroup interviews the worker held with each woman and by the elaborate care she took with the practical arrangements for the meetings. The importance of these arrangements is stressed, and the worker's report of them is quoted in full. The development of group cohesiveness is traced, and the tensions that arose over the domination of the group by its more verbal members is discussed. The authors indicate that the task of steering the discussions in this kind of open-ended group can be a stressful experience for the social worker. The worker must be prepared to be directly challenged and tested. A transcript of some group discussion on sex is provided to illustrate the kind of verbal interaction that occurs. The difficulties the worker faced in deciding how much to reveal herself when challenged by group members is discussed. The authors conclude by reporting the group's positive effects in helping members to retain ties to the larger society, to gain some perspective on attempts to cope with the tasks of motherhood, and to strengthen their capacity to meet the demands placed on them. Quotes are included from the worker's final summaries of two of the group members; these are considered representative of what occurred with most of the women involved.

240.

Luepker, Ellen T. Joint admission and evaluation of postpartum psychiatric patients and their infants. ***Hospital and Community Psychiatry*, 23(9):284-286, 1972.**

Luepker evaluates the practice of admitting infants to adult psychiatric hospital wards as a part of the treatment plan for mothers with postpartum psychiatric problems. The program was based on Melges' theory that postpartum mental illness is frequently related to problems in assuming the mothering role. For the purpose of the evaluation, 13 of the 19 mother-infant pairs admitted to the hospital between April 1961 and July 1965 were studied. Twelve mothers and 11 fathers agreed to participate in interviews, 1 to 5 years following the hospitalization, which focused on their feelings about the experience and its effects on the mother and the family during and after the hospitalization. At the time of admission most of the women were between the ages of 20 and 34—one woman was over 40 and another was younger than 20. All the women were white, middle- or upper-class, and this was the first marriage for all but one woman. Most of the infants were admitted between 6 to 9 days after their mothers. Generally, the babies stayed in a separate locked room connected by intercom with the nurses' station, and the nurses either cared for the infants themselves or the mothers accompanied them to the nursery. All but one of the mothers reported that the infant's presence had been helpful to her — nine considering it crucial to their recovery and two believing it to be of secondary importance but helpful in some respects. Some of the mothers expressed the feeling that learning to care for the baby had been important to their recovery. Additionally, most of the mothers indicated that as a result of the joint admission program their self-esteem and ability to cope increased. Every father who was interviewed recalled a sense of relief when the mother and infant were together again, for this enabled him to deal with his responsibilities to them jointly. The records of the three women who considered the baby's presence as less helpful revealed a history of emotional problems that related to other life tasks than mothering. Luepker concludes that the program proved most beneficial to women whose primary problem was the mother-infant relationship.

241.

Moreno, Zerka T. Psychodrama of young mothers. *Group Psychotherapy and Psychodrama*, 27(1-4):191-203, 1974.

Moreno reports that psychodrama offers systematic action training for the role of mother. Psychodramatic techniques are effective in helping to clear up distorted perceptions, false anticipations, and morbid presentiments that, if left unresolved, could contribute to mother-child conflicts. Problems with anxious anticipation about the birth of a child and its effects, as well as problems in the self-perceptions of pregnant women, are identified. Moreno asserts that these conflicts are difficult to resolve on a verbal level, because they are deeply rooted in the framework of the psyche. An example is given of how psychodrama can be used diagnostically. In the case described the "double technique" and "future projection technique" helped a woman reveal her severe unacknowledged anxieties about childbirth. The post-psychodramatic interview revealed her specific fears, and treatment was recommended. The author goes on to discuss how psychodrama can help in therapeutic mother-role training. This work is usually done with a group of pregnant women who are unfamiliar with babies and want the security of knowing what to do in advance. An example is provided of how a "rehearsal for future" was used in such a group to enable the women to begin to feel the reality of their babies by projecting a year into the future. The mothers' concerns over such things as the sex of their babies were revealed in dealing with the period of time immediately following birth. Role reversals and psychodramatic projections permitted women to explore their conflict areas. Examples of psychodrama used to treat a case of labor trauma and the problem of successive spontaneous abortions are also included. The author relates that psychodramatic application can be urgently needed by women during the first weeks after childbirth, since mothers often have false apprehensions about what is going on in their baby's mind. Group treatment is indicated at this time, since problems are fairly universal. An example is given of a group of young mothers in which "auxiliary egos" (therapeutic aides) were used to facilitate understanding of problems about feeding, sleeping, and crying. Moreno concludes that psychodrama can help mothers to accept life as it is and to become more relaxed in relation to their infants.

242.

Singer, Ann. A program for young mothers and their babies. *Social Casework*, 52(9):567-577, 1971.

A "Young Mothers Club" which operated in New York City from 1967 until 1970 is described. A plan to provide group therapy to pregnant teenagers led after a few months to broader use of staff skill and interest. Housed in a Community Mental Health Center, the club became a day center with a school program, group work, individual counseling, health education, and social activities. Singer describes the team approach used by the staff and how the lack of privacy in the facility created a family-like atmosphere that broke down communication barriers. Although daily planning conferences and weekly meetings were held for evaluation and long-range planning, the center was run very informally. Staff members learned each other's skills and worked with the young mothers who felt most comfortable with them. A profile of the clients seen in the center is provided. Most were from 15 to 18 years of age and lived with their mothers in a welfare-supported household within a mile of the center. The majority enrolled in the center's school program and later returned to public school. Singer reports that the multiplicity and complexity of the problems faced by these young women were often staggering. It was essential to establish short-term goals and be ready to act upon them. Each young woman was encouraged to explore her lifestyle and try out new approaches. Staff style was variable and experimental. Singer describes in detail the work performed by specific staff members—the consulting psychiatrist, consulting pediatrician, social worker, public health nurse, social work technician, secretaries who came from the same background as the participants, volunteers, and teachers. Food was provided, since hunger proved to be a very real problem in this group. A case illustration of the kinds of problems encountered and the involvement between the girls and staff members is included. Singer indicates that down-to-earth practical involvement was chosen as the method of intervention most effective in preventing crises from limiting the growth of the adolescents and their babies. Credit was always given to each girl's capacity for evaluating behavior and motivation. The informality of the center enabled them to feel comfortable and accepted. She points out the necessity for reevaluating the social norms that maintain the illegitimacy-poverty-welfare cycle. An ideal program, Singer concludes, would provide medical and social care along with housing, education, and baby tending in the young woman's own neighborhood.

243.

Wilborn, Bobbie L. The myth of the perfect mother. *The Counseling Psychologist*, 6(2):42-45, 1976.

Wilborn presents a mode of counseling based on the philosophy and work of Adler and Dreikurs. Its objective is to help mothers free themselves from the destructive myth of the perfect mother. Many women believe in this myth and feel that they have total responsibility for their children's behavior—that if they can perform perfectly in their role, their children will also behave perfectly. They fail to perceive their relationship with their child as part of a developmental process with ups and downs. Because of unrealistic expectations, they come to feel like failures. Their children also lose self-confidence, for they cannot possibly live up to such perfect standards, and the mother-child relationship becomes one of conflict. Wilborn suggests that society's present state of transition also creates problems in the mother-child relationship. Mothers often model their behavior on that of their own parents, but the autocratic methods of the past do not work with children growing up in today's more egalitarian society. Parents must now be understanding and use authority more rationally. The first phase of Adlerian counseling is described as the establishment of a good equal relationship between counselor and client through understanding and encouragement. The client comes to recognize her own role in creating problems; she also learns that her problems are based on faulty perceptions, learning, and values that can be corrected. The mother becomes aware of herself as a competent person and realizes that with work good relationships can be achieved. She acquires insight into her own behavior, realizing that she merely provides an atmosphere for her children and is not responsible for their particular behavior, Additionally, the mother learns that she and her children have been interacting in patterns that can be changed. When the mother begins to believe in her own personal worth and to identify the contradiction between her perfect-mother goals and what really can be done, she can act effectively to provide her children with a climate for growth. In the final phase of therapy, the mother is encouraged by the counselor to actively reorient interactions with her child. In this phase she is helped to understand her child's misbehavior, as presented by Dreikurs, and to deal with her child in the understanding and encouraging way the counselor has dealt with her. The author concludes that both mothers and children need to change in order to establish positive relationships. Mothers must change their basic concept of what the relationship between parents and children should be so that they can use the techniques of encouragement and logical consequences that will allow them to enjoy their interactions and help their children develop into responsible human beings.

244.

Witkin, Lynne J. Mothers' discussion groups in public libraries. *Social Work*, 21(6):525-526, 1976.

A short report of an outreach program developed for mothers by the Community Mental Health Services for three New Jersey communities is presented. The public library in each area was identified as a valuable point of entry for the delivery of preventive mental health services. Mothers' discussion groups were organized to take place during the ongoing program of a story hour for preschool age children. The goal was to enhance and expand the mothers' problem-solving capacity through professionally led group interaction. The leader would facilitate the sharing of experiences concerning child-rearing issues and related problems. Descriptions concerning the length and format developed by different discussion groups are presented. An example is provided of the cognitive and affective learning that occurs and that can be helpful to parents when problems similar to those discussed in the group arise in their own families. The author discusses the natural and gradual shifting of emphasis from child to parent that has evolved in several groups. The mothers begin to talk about themselves and to deal with their satisfactions and dissatisfactions in their roles as women, wives, and mothers. In one conservative and predominantly Italian community, some women expressed feelings of helplessness and anger, seeing no alternative to their culturally defined parent-homemaker role. The group dealt with this by providing support and giving suggestions for ego-enhancing alternative activities. In another group, the women spoke of the feelings of loneliness and isolation they experience in their role as suburban housewives and their desire for meaningful interaction with other adults. The group leaders have encouraged this focus on the mothers rather than on their children, believing that greater recognition and gratification of the women's needs should lead to happier and healthier mothering and more comfortable family interactions. The author concludes that these discussion groups have become a valuable support system for the mothers in these communities.

Sexuality/Sexual Dysfunction

245.

Barbach, Lonnie Garfield. Group treatment of preorgasmic women. *Journal of Sex and Marital Therapy*, 1(2):139-145, 1974.

Barbach reports on the first 83 women who participated in a group treatment program for preorgasmic women that was developed at the University of California in Berkeley in 1972. The program allowed a number of dysfunctional women to receive low-cost treatment regardless of whether they had sexual partners. Masturbation was the main learning tool, and male partners were excluded from direct treatment. The 83 women who participated initially (groups of six met twice weekly for 5 weeks with two female cotherapists) were between the ages of 19 and 48 and from various racial, religious, economic, educational, and work backgrounds. In the group meetings, women focused on early sexual trauma and their feelings of shame about sex and masturbation; they explored the subtle messages their families and society had communicated to them. "Homeplay" exercises — based on a modified version of Lobitz and LoPiccolo's (1972) nine-step masturbation program — were assigned at each session. Specifics of the sessions and the homeplay assignments are included. After a woman has become proficient in experiencing orgasm with masturbation, homeplay that includes her partner, if she has one, is assigned. The homeplay exercises at this time stress the necessity of specific and direct communication if the woman is to become orgasmic in the relationship. Rather than emphasize orgasm through intercourse as a goal for the women, the effort is made to expand their repertoire of sexual activities by encouraging them to seek sexual satisfaction in any manner acceptable to both partners. Of the first group of 83 women who participated in the program, 91.6 percent were orgasmic with masturbation by the end of the 10 sessions. When the groups terminated, the women also reported enhanced self-esteem, increased assertiveness and expression of feelings, body and sexual acceptance, and increased satisfaction with intimate relationships. Seventeen women were questioned as to their orgasmic status 8 months after their last session. All 17 women continued to be orgasmic with masturbation. Additionally, seven women were orgasmic with their partners during 90 to 100 percent of their sexual encounters; four achieved a 50 percent orgasmic rate; three were orgasmic less than 50 percent of the time; two still had not achieved orgasm with their partners; and one person did not have a partner. The author also reports on additional questionnaire information that was obtained at this time along with the responses of male partners of 13 of the 17 women. Continued progress is also noted, for one woman called 1 year after treatment to report her first orgasm during coitus, suggesting that the treatment program provides techniques that women can use after therapy ends. The factors identified as essentially responsible for the reversal of the orgasmic dysfunction are the use of masturbation as opposed to partner stimulation as the primary learning technique, the support and "permission giving" aspects of the group, and the ability of the group leaders to overcome resistance and ensure that the client assumes responsibility for her own orgasm.

246.

DeMoor, W. Vaginismus: Etiology and treatment. *American Journal of Psychotherapy*, 26(2):207-215, 1972.

This article's purpose is to close the existing information gap concerning the syndrome of vaginismus. DeMoor provides a complete anatomical, physiological, and psychological definition of this psychosomatic illness that affects women's sexual response by severely or totally impeding coital function through the involuntary spastic contraction of the vaginal outlet. The syndrome is presented as phobic in nature with anxiety identified as its central constituent. DeMoor writes that vaginismus should be considered as a problem involving both sexual partners, since it not uncommonly causes secondary impotence in the male. The psychoanalytic view of vaginismus as an expression of unconscious "revenge type" behavior as a result of the castration complex is discussed. The author cites Masters and Johnson in presenting the three most common psychological causes of vaginismus. The syndrome has been found most frequently to be associated with the inhibiting influence of excessive religious orthodoxy. In order cases vaginismus appears subsequent to episodes of psychosexual trauma, or it may occur when a woman with prior homosexual identification attempts heterosexual function. DeMoor concludes that vaginismus can generally be viewed as a learned inhibitory behavior pattern due to some kind of malconditioning. A six-step treatment procedure is based on the assumption that the male partner is sexually adequate. Treatment requires the cooperation of both partners, is nonpunitive, and is reassuring in tone. The mechanism of the involuntary spasm is explained in as much detail as possible, and the technique of vaginal dilation using lubricated glass dilators of progressively increasing sizes is employed. Sex is not permitted until both partners feel confident enough to attempt coitus. Instruction is given on relevant sexual manipulations and establishing an affectional relationship. Despite the procedure's reported success in relieving involuntary vaginal spasms, in a minority of cases some women may still remain nonorgasmic. The possible causes of this—transient dyspareunia, anticipatory fears, and frigidity—are discussed, and methods of overcoming these dysfunctions are presented.

247.

Ellis, Albert. The treatment of sex and love problems in women. In: Franks, Violet, and Burtle, Vasanti, eds. ***Women in Therapy: New Psychotherapies for a Changing Society.*** **New York: Brunner/Mazel, 1974. pp. 284-306.**

Ellis contends that the sex and love problems of women, whether "natural" or culturally produced, are exacerbated by this male-dominated society. If solutions to women's problems are to be found, the societal order will have to be significantly changed. Within the existing social mode, the vast majority of women, as well as men, suffer from one or more sex and love difficulties. Ellis presents rational-emotive therapy as a treatment approach for women who are experiencing these difficulties and identifies four types of problems based on contact with clients. The first one is labeled "love slobbism." These women tend to make love their entire existence, and if they are not being fulfilled will go to any length to get the approval they seek. With no love guarantees, the woman feels desperately lonely, depressed, and worthless. The therapist must move the patient to dispute her irrational beliefs and change her evaluations of events by teaching her the logico-empirical method of challenging her irrational hypothesis. The desire for an intimate relationship is healthy, but it is unhealthy for this desire to be felt as a desperate need. The woman with the second problem, "sex-love hostility," becomes so angry and jealous at feeling neglected or rejected by her lover that she helps ruin the relationship herself. Women with this problem must be aided to be rational and deal only with the behavior problem manifested instead of being all-demanding and hostile. The third problem is sexual inadequacy. Here, feelings of desperation at having to achieve create anxiety that may subsequently lead to sexual inadequacy. Ellis briefly discusses several treatment techniques. They include "antiawfulizing," sensate focus assignments, teaching the client unconditional self-acceptance, *in vivo* desensitization, sexual imaging, directing the client in rational-emotive imagery, and operant conditioning. Patients with the fourth problem, sexual and general unassertiveness, are trained in assertiveness through "activity homework assignments." Role playing is also used to assist them. Ellis describes rational-emotive therapy as being aimed at helping women make a basic philosophical change so that they can overcome both existing and future problems. It teaches a method for dealing with problems and helps women to accept themselves as complete people with the right to pursue goals and relationships.

248.

Freiberg, Patricia, and Bridwell, Margaret W. An interdisciplinary approach to female sexuality. *The Counseling Psychologist*, 5(1): 106-111, 1975.

The authors present a combined approach to female sexuality based on their years of work in a gynecologist-psychologist partnership in a college health center. They suggest that gynecological patients rarely have just physical symptoms and that problems with sexuality are often masked as medical questions or physiological complaints. Working as a team, the authors created a group counseling program to deal with sexual identity problems. The formation of the group is described, indicating that the combination of the two disciplines provided group members with a particularly strong sense of security. The gynecologist was able to allay medical concerns, freeing the participants to focus on the psychological causes of problems. The authors suggest that women's sexual dysfunction is related to the historical interpretation of their sexual role by male theorists. The focus of the discussion then turns to the 11 possible causes of sexual dysfunction, ranging from a strict religious upbringing to lack of sex education to having an inadequate male partner. An example is given of how a physical condition can create a psychological problem that will inhibit sexual function and how the cooperative efforts of a gynecologist and psychologist are appropriate in such cases. Dyspareunia and vaginismus are discussed, as is the importance of a gynecological examination to determine if there are physical causes for these conditions. The authors report, however, that the most frequent causes of these problems were psychological in the college women they saw. They assert that the way a woman is treated at her initial pelvic examination can affect her feelings about herself and her sexuality, and they suggest ways to help patients feel more comfortable with their bodies. The final section of the paper is devoted to contraception, which, according to the authors, involves both the psyche and medical treatment. Although often overlooked, the emotional acceptance of a form of birth control is considered very important by the authors, who advise that women seeking contraception be treated with understanding and care. The different contraceptive methods available are discussed in terms of psychological and medical concerns. The authors report that young women requesting birth control are often asking for advice and support regarding their sexual activity and suggest that male partners be included in this counseling. They conclude by noting that their interdisciplinary partnership has been valuable in treating college-age patients and in training of paraprofessionals, nurses, and volunteers to work with women.

249.

Husted, June R. Desensitization procedures in dealing with female sexual dysfunction. ***The Counseling Psychologist,*** **5(1):30-37, 1975.**

This article deals with the use of systematic desensitization to treat sexual dysfunction in women. Desensitization using imagery and deep muscle relaxation response is identified as an efficient treatment mode that is especially helpful for patients who find the current modes of behavioral therapy unworkable. Systematic desensitization is a counter conditioning process developed by Wolpe (1958) in which a nonanxious response is elicited, generally through the use of relaxation or sexual or assertive responses, from stimuli that normally produce anxiety. Desensitization is most effectively used for treating women with vaginismus or aversion and anxiety reactions to sexual situations. Deep muscle relaxation is the response used most widely as antagonistic to anxiety. Husted points out that for desensitization treatment a list of situations relevant to the client's experience must be developed. She includes a table that rates sexual hierarchy items chosen from 30 previously treated patients and notes that if relaxation response is to be used for the counter conditioning process, the client must be taught deep muscle relaxation exercises as developed by Jacobson. Treatment consists of presenting these anxiety-producing situations to the client in ascending order until the relaxation response effectively eliminates the anxiety reaction. This process is explained in detail. Husted reports on an experiment she devised to compare sexual response and relaxation response using imagery as modes of desensitization. Additional techniques that might aid the effectiveness of therapy were eliminated. Half the women were treated with the relaxation/visualization method while the other half were treated using *in vivo* sexual responses introduced in a progressively more intimate manner. The number of subjects involved is not given. The most important information obtained was the greater efficiency of the relaxation/visualization method. Statistical analysis revealed a highly significant difference in the number of sessions required by the two methods of desensitization ($p < .001$), an average of 7.8 imaginal desensitization sessions in contrast to an average of 13.3 *in vivo* desensitization sessions. Desensitization markedly reduced anxiety regardless of the method that was used. This anxiety reduction was accompanied by increases in sexual activity and responsiveness although not necessarily an increase in orgasm. Husted concludes that (1) desensitization using relaxation response with visualization can bring the client to a stage of enjoyment where further techniques can be introduced; (2) the client's realization that she can learn to overcome her problem is important in reducing tension; and (3) physical and mechanical methods seem to be an important adjunct to therapy in nonorgasmic women.

250.

Jankovich, Rebecca Ann. Treatment of orgasmic dysfunction using women's groups. (Abstract source, *Dissertation Abstracts International*, 36(B):912, 1975.) *Dissertation Abstracts International.* Ann Arbor, Mich.: University Microfilms, No. 75-17704. 95 pp.

Twenty-three women who were either preorgasmic or situationally anorgasmic participated in a research program designed to determine the relative efficacy of treatment variables in reversing orgasmic dysfunction. Three treatment program variables were used: (1) a 2½-hour audiovisual presentation of information on sexual anatomy; (2) a 2-hour presentation of information on LoPiccolo's self-stimulation program and female consciousness-raising issues; and (3) eight 2-hour sessions of group therapy focused on sensuality and LoPiccolo's self-stimulation program. All 23 subjects participated in treatment program 1; eight of these women "dropped out" at this point and they constituted group 1. The remaining 15 subjects were in treatment program 2, following which eight "dropped out;" these constituted group 2. The remaining seven subjects, group 3, additionally experienced the third treatment program variable. Self-report data were collected from each subject concerning the number of daily attempts at self-stimulation, efforts to have relations with a partner, and experiences of orgasm. At the study's conclusion, women in groups 1 and 2 were offered the opportunity to participate in a post-study group, six sessions of group therapy. The author reports that all three combinations of treatment variables helped women who had not experienced orgasm in the 6 weeks preceding the study to begin experiencing orgasm. The number of women in group 1 who began experiencing orgasm after watching an audiovisual presentation on sexual anatomy was not significantly different from the number of women who began experiencing orgasm after participating in all three of the treatment program variables (group 3). The number of group 2 women who began experiencing orgasm after participating in treatment program variables 1 and 2 was significantly smaller than the number in groups 1 or 3. Based on her results, the author suggests that the provision of either psychological permission to experience sensual feelings or information on self-stimulation to effect a change in orgasmic dysfunction may be unnecessary. The effect of presentation of information alone, as with group 1, is described as a much more powerful therapeutic technique than anticipated. Additionally, the author reports that the group therapy experience of group 3 appeared to induce significantly different clinical changes: the women made more attempts at self-stimulation and relations with partners and experienced more orgasms than the women in groups 1 and 2, and the women reported feeling more comfortable with discussing sexual topics and details of their sexual behavior than women in groups 1 and 2. Post-study group women reported the same feelings. Jankovich also describes and makes suggestions concerning the unexpected negative reactions of the partners of the women participating in the group therapy experience and the post-study group.

251.

Joseph, Edward D. An aspect of female frigidity. ***Journal of the American Psychoanalytic Association*****, 22(1):116-122, 1974.**

A brief review of psychoanalytic theories of frigidity and a fragment from the analysis of a "frigid" woman are presented. Joseph writes that the concept of frigidity as indirect gratification of, or defense against, hostile and/or libidinal fantasies is implicit in the psychoanalytic literature. He believes that the literature has not sufficiently emphasized the possibility that frigidity may help to maintain a significant libidinal fantasy from the oedipal period. To support this contention, Joseph describes a patient, in her early forties and from an intellectual background, who sought therapy because of general dissatisfaction with her life. Although her marriage of 22 years was described as a good one, the patient rarely achieved orgasm and considered sex a duty. As analysis progressed and aspects of the patient's sexual life were worked out, her attitude toward sex changed and she began to experience increased sexuality and a "vaginal type of orgasm." Her frigidity appeared to be yielding to increased understanding. Some oedipal fantasies about her father were coming to the fore; these were worked through as were some feelings of guilt concerning her mother. Joseph next reports on an unexpected phase of analysis that occurred after the patient's husband touched her clitoris during intercourse. The patient had a blind spot (scotomata) about the anatomy of her genitals and could not recall experiencing the feeling that the touching of her clitoris aroused in her. She began to examine herself and to review her previous sexual experience. Through the interpretation of a dream of the patient's, the analyst determined that she had a fantasy that separated the clitoris from the rest of the genital region and isolated it as the exclusive preserve reserved for the father of her childhood and, in terms of a father transference, for the analyst. This area had never been involved in relations with other men. Joseph reviews Freud's analysis of the female child's shift away from interest in her clitoris and her mother to centering attention on the father in the oedipal phase. He contends that in this patient the fantasy of sex with her father centered around her clitoris. This was never given up but was isolated from the rest of her libidinal development. Even when analysis freed her for vaginal responsiveness in sex, her clitoris was bypassed. In this case, the author maintains, frigidity was in the service of libidinal gratification of an infantile oedipal fantasy rather than in the gratification of hostile impulses or fantasies of revenge as frigidity is usually interpreted. He concludes that the patient's clitoral sensations were restored to her after her fantasy was uncovered through transference.

252.

Kaplan, Helen Singer. General sexual dysfunction (frigidity). In: Kaplan, Helen Singer. ***The New Sex Therapy: Active Treatment of Sexual Dysfunctions.*** **New York: Brunner/Mazel, 1974. pp. 661-373.**

A couples approach to the treatment of general sexual dysfunction in women is presented. Frigidity is defined and described as well as distinguished from orgastic dysfunction. Kaplan points out that women vary far more in their psychological reactions to sexual dysfunction than men do and that this difference is in large part culturally determined. Women are not expected to perform sexually as men are. Some women accept their condition and endure nonarousing sex without bad effects; others develop resentment toward their husbands and come to feel self-hatred and depression. A psychosomatic concept of general sexual dysfunction is presented. Since female sexual arousal is a visceral reaction, it is controlled by the autonomic nervous system whose functions are highly vulnerable to disruption by emotional arousal. Kaplan notes that the anxiety that impairs sexual response is not always caused by unconscious unresolved conflict, but may well have its source in the present situation. Although the psychodynamically oriented treatment presented here does not ignore deeper problems, its primary concern is with modifying the immediate sources of the sexual difficulty. The aim of this sex therapy is to facilitate the woman's abandonment to sexual experiences by changing the sexual system in which she functions. The therapist attempts to do this by creating a nondemanding, relaxed, and sensuous ambience which will permit the unfolding of sensual response during lovemaking. The systematic assignment of various sensuous and erotic experiences is an effective means of removing some immediate obstacles to sexual functioning. A detailed description is given of the usual sequence of prescribed sexual tasks. The first task is the sensate focus, or nondemand pleasuring, exercise developed by Masters and Johnson in which erotic contact is limited to gentle touching and caressing each other's bodies. This relieves the woman of the pressure of bringing her partner to orgasm and allows her to focus on her own erotic and sensuous experiences. When this yields a positive response, the couple proceeds to light teasing genital play. If a woman's problems are not due to complex intrapsychic factors, the genital stimulation exercises usually produce a marked increase in responsiveness. When genital play is met with favorably, the next step is nondemand coitus, conducted in response to the woman's sensations and feelings with no pressure to produce orgasm. In discussing the therapeutic sessions, Kaplan reports that problems which arise in the sexual exercises enable the therapist to identify the specific obstacles that impede sexual responsiveness. The anxiety sex creates is lessened through desensitization using prescribed exercises. The intrapsychic and transactional factors that gave rise to the conflict over sexuality are dealt with verbally in the conjoint sessions. Kaplan points out that the integrated use of sexual exercises with psychotherapy sessions is the distinctive feature of sex therapy. A case history is provided to illustrate how this works. In conclusion Kaplan indicates that it is primarily the woman whose sexual response is blocked by deep hostility or conflict who is not helped by such brief experientially oriented methods.

253.

Kaplan, Helen Singer. Orgastic dysfunction. In: Kaplan, Helen Singer. *The New Sex Therapy: Active Treatment of Sexual Dysfunctions.* New York: Brunner/Mazel, 1974. pp. 374-411.

In this chapter Kaplan deals with the treatment of orgastic dysfunction in women. The term is defined and its symptoms are described. Women who suffer from orgastic dysfunction may thoroughly enjoy sex but are unable to move beyond the plateau phase of sexual response. The traditional psychoanalytic concept of two orgasms, vaginal and clitoral, is reviewed. Current research indicates that there is but one kind of female orgasm, which has both clitoral and vaginal components. Although some clinicians define coital orgasm as the only "authentic" orgasm, Kaplan contends that the inability to achieve coital orgasm may well be within the realm of female sexual normalcy. She suggests that treatment decisions about women who seek therapy for this inability must be based on a rational concept of the relationship between coitus and female orgasm, which she discusses in some detail. The reflex concept of the female orgasm that forms the basis for her treatment approach is set forth. Although there are no hard data on what constitutes normality in the area of the female orgasm, Kaplan believes that the extremes of sexual inhibition are pathological and that women with specific orgastic inhibitions can benefit from sex therapy. The various reactions women have to their dysfunctions are discussed as are the various possible causes. The treatment for orgastic dysfunction is an integrated combination of prescribed sexual experiences and psychotherapy with an objective of eliminating the patient's involuntary control of the orgastic reflex. The sexual exercises are designed to help the woman stop interfering with the natural occurence of orgasm, while the psychotherapy is used to bring about an awareness and resolution of the conflicts that orginally caused the holding back. Treatment designed for women with absolute orgastic dysfunction is described first. The initial therapeutic objective is to help these women achieve their first orgasm. Although most sex therapy involves both patients, individual therapy is used initially in treating primary orgastic dysfunction. The prescribed exercises are described in detail. Masturbation is assigned first, and if this fails to evoke orgasm the patient is advised to use a vibrator. This intense stimulation usually enables women to reach orgasm. These exercises are supplemented with a psychotherapeutic exploration of the patient's fears of orgasm when orgasm is still inhibited. The use of distraction and muscle involvement to achieve orgasm is also discussed. After the woman is able to masturbate to orgasm fairly easily, the partner is involved in treatment. Kaplan notes that although most women are able to achieve orgasm by the above methods, the transfer to orgasm in the presence of the partner is sometimes difficult. Two case histories are presented to illustrate alternative reactions to the attainment of orgasm by masturbation Treatment for situational orgastic dysfunction is aimed at resolving specific conflicts that inhibit the patient in the nonorgastic situation. Kaplan points out that the alleviation of a specific sexual dysfunction often alters the quality of the total marital relationship and profoundly changes each partner's attitude toward sex and her/himself. Obstacles to sexual responsiveness in women that appear often in therapy are women's attitudes of helplessness, passivity, and dependence on the man that are accompanied by fear of abandonment, as well as feelings of guilt and shame about sexuality. Successfully completed sex therapy often enables women to better express their needs in other areas of life.

254.

Kaplan, Helen Singer. Vaginismus. In: Kaplan, Helen Singer. *The New Sex Therapy: Active Treatment of Sexual Dysfunctions.* New York: Brunner/Mazel, 1974. pp. 412-430.

Focusing on the treatment of vaginismus in sex therapy, Kaplan initially defines and describes the syndrome. She explains that whenever vaginal penetration is attempted, the vaginal introitus closes so tightly that intercourse is not possible. She discusses the reactions of women and their partners to vaginismus, indicating that the phobic avoidance pattern that is often operant around intercourse is the major obstacle to successful treatment. Vaginismus is identified as a conditioned response that results from the association of pain or fear with attempts at vaginal penetration. Kaplan presents the possible physical causes of vaginismus and the psychoanalytic formulations about the source of vaginismus as well as the etiological hypotheses of Masters and Johnson and others who have written about these patients. She concludes that a wide variety of factors can be involved in the creation of the dysfunction. Treatment is primarily concerned with changing the immediate cause of vaginismus -- the conditioned response — and only deals with the deeper causes if they present an obstacle to desensitization. Given that all physical pain-producing conditions have been corrected, the elimination of the patient's phobic avoidance is the first step in treatment. The author describes various techniques used to accomplish this and concludes with her own approach. She assumes that vaginismus is a conditioned response that will yield readily to *in vivo* extinction procedures as long as the patient is not frightened or repelled by the process of gradually dilating her vagina. Kaplan reports that the techniques specifically designed to overcome phobias are seldom needed if the patient is given reassurance and support, rapid interpretation of the unconscious components of her fears, and confronted with the fact that she cannot be cured until she is able to insert something into her vagina. Both the sexual task assignments and conjoint therapeutic sessions are designed to reduce the patient's anxiety so she can proceed with dilation. A detailed account is given of the steps of the *in vivo* desensitization that takes place at the patient's own pace, in her own home, with either the patient or her partner inserting one finger, then two, in the vagina until she is comfortable enough for coitus to be attempted. The author acknowledges that in some cases the phobia is so severe that the patient cannot submit to this kind of regimen and the therapist must be prepared to work with her on a deeper psychotherapeutic level. Kaplan reports that the most useful therapeutic maneuver in treating vaginismus has been encouraging patients to "stay with" their unpleasant feelings rather than avoiding them. A case history is presented to illustrate how the treatment of vaginismus may proceed. Kaplan relates that sex therapy that combines *in vivo* desensitization with conjoint therapy offers the most hope for treating vaginismus. Clinical data suggest that any therapeutic variation will be effective if it works toward eliminating the patient's conditioned response by getting her to gradually dilate her vagina under relaxed conditions.

255.

Kohlenberg, Robert J. Directed masturbation and the treatment of primary orgasmic dysfunction. ***Archives of Sexual Behavior*****, 3(4): 349-356, 1974.**

Kohlenberg reports on his evaluation of the effectiveness of directed masturbation as an adjunct to the treatment of primary orgasmic dysfunction. The subjects were three couples who had participated in a treatment program modeled after that of Masters and Johnson (1970). The females in these couples indicated that sexual encounters were not arousing and that they had not experienced orgasm. The treatment plan for the three couples, who were seen primarily on a weekly basis, was again modeled after that of Masters and Johnson. Couple 1 was seen by a male-female co-therapist team, whereas couples 2 and 3 were seen by a male therapist alone. Masturbation as a therapeutic procedure was introduced after several months of the basic Masters and Johnson treatment program, and the author describes the 5-week procedure that was used. All three women were classified as primary inorgasmic, and all had undergone recent gynecological examinations that indicated no organic basis for sexual dysfunction. The sexual histories of each couple are included. Four types of data were collected after treatment began: the occurrence of orgasmic experiences during masturbation and during coitus, and self-ratings of sexual arousal experiences during the husband-wife sexual encounter and during self-stimulating sessions. Arousal ratings were made on a 0-10 point scale after each experience and turned in at the weekly therapy session. All three females reported no orgasms, either self-induced or during coitus, before the introduction of directed masturbation. Orgasms through masturbation were reported by the women after 3 weeks of directed masturbation with couple 1, after 4 weeks with couple 2, and after 6 weeks with couple 3. Ratings of sexual encounters involving the husband and wife also increased after directed masturbation began. Increased arousal in the self-stimulating experience appeared to anticipate increased arousal in husband-wife interactions. The occurrence of orgasm during masturbation also anticipated orgasm during intromission. Female orgasmic experience during intromission occurred for all three couples several weeks after the first self-induced orgasmic experience. Followup data were obtained monthly for 6 months after treatment. All three females reported that they were orgasmic on at least 50 percent of those occasions during which intromission occurred. Subsequent to this study an additional four couples have participated in this treatment procedure; all four females have experienced orgasm during coitus after 11 or fewer treatment sessions. The author discusses the single therapist versus co-therapist variable and indicates that it does not appear to be significant in their clinic program. On the basis of this study, Kohlenberg concludes that directed masturbation can be an effective therapeutic technique. He emphasizes, however, that the directed masturbation is an adjunctive procedure and that the data do not warrant the use of this technique without a adequate counseling program.

256.

LoPiccolo, Joseph, and Lobitz, W. Charles. The role of masturbation in the treatment of orgasmic dysfunction. *Archives of Sexual Behavior,* **2(2):163-171, 1972.**

LoPiccolo and Lobitz discuss the role of directed masturbation in therapy at the University of Oregon Psychology Clinic Sexual Research Program. Describing masturbation as the technique most likely to produce orgasm and to produce the most intense orgasm, they conclude that it logically becomes the preferred treatment for enhancing orgasmic potential in primary inorgasmic women (women who have never experienced an orgasm from any source of physical stimulation). The authors use the masturbation component they developed as an adjunct to a behavioral time-limited (15 sessions) treatment program which involves both the husband and wife and which is modeled very directly after the Masters and Johnson procedures for treating inorgasmic women. They describe the course of treatment, indicating that initially, in prescribing a masturbation program, the therapist's first step is to deal with both partners' attitudes toward masturbation. Techniques which can be used to overcome negative attitudes toward masturbation are discussed. Modeling and role-playing techniques are used to train the husband to be supportive of his wife's masturbation. The masturbation program, which is explained in detail to the husband and wife, generally consists of nine steps, with the client typically working on one step each week. The nine steps are described along with case history data to exemplify the principles involved: (1) increasing self-awareness by visually examining genitals and performing a program of exercises for increasing the tone and vascularity of the pelvic musculature; (2) exploring genitals tactually as well as visually; (3) continuing visual and tactual exploration of genitals with emphasis on locating sensitive areas that produce feelings of pleasure; (4) concentrating on manual stimulation of the plessure-producing areas; (5) increasing the intensity and duration of masturbation if orgasm has not occurred in the previous step; (6) masturbation with a vibrator and using pornographic material if orgasm has not occurred in the previous step; (7) masturbation with husband observing once orgasm has been achieved through masturbation; (8) husband doing for his wife whatever she has been doing for herself in order to achieve orgasm; and (9) engaging in intercourse (once orgasm has been achieved in step eight) while husband concurrently stimulates the wife's genitals either manually or with a vibrator. The authors note that once orgasm has occurred at step nine the woman should logically be considered "cured," since the clitoris and not the vagina is now known to be the major locus of sexuality and orgasm in normal women. They discuss the effectiveness of this program, reporting that the eight women who completed the 15 therapy sessions all gained the ability to achieve orgasm, and six have achieved and continued to achieve orgasm during intercourse with their husbands. Acknowledging the smallness of the sample, LoPiccolo and Lobitz conclude that this masturbation program offers considerable promise in the treatment of primary orgasmic dysfunction.

257.

Masters, William H., and Johnson, Virginia E. *Human Sexual Inadequacy*. Boston: Little, Brown and Company, 1970. 467 pp.

The authors describe their Reproductive Biology Research Foundation's 2-week rapid education and symptom reversal treatment approach to sexual dysfunction. Current treatment concepts are based on a combination of 15 years of laboratory experimentation and 11 years of trial and error. Discussing therapy concepts, Masters and Johnson identify the marital relationship as "the patient" and suggest that dual-sex teams can provide a more successful clinical approach to problems of sexual dysfunction than an individual male or female therapist. After elaborating upon therapists' role and therapeutic guidelines and procedures, they detail the course of a couple's first 4 days at the Foundation, focusing on history taking, the roundtable discussion, the required physical examination and laboratory evaluation to first rule out organic problems, and the initiation of the use of sensate focus. With touch as the basic medium of exchange, the sensate focus physical procedure offers the marital unit a way to learn that sexual function is more than physical expression. This procedure and the rules of exchange to be followed by the couple are described. The basic instruction of the fourth day and all other days is to repeat the previous sensate-focus opportunities (the opportunity "to share physical giving of pleasure without the pressure of real or implied sexual goals") before following any other physical directions; the intention is to make the sensate focus concept an integral part of the couple's interaction. Attention after the fourth day is on treatment of specific varieties of sexual dysfunction. These are discussed in separate chapters, which include the format for subsequent days' therapy direction and which presume established marital unit familiarity with the concept of and approaches to sensate focus. Premature ejaculation, ejaculatory incompetence, primary impotence, and secondary impotence are dealt with in four chapters. In a chapter on vaginismus, the authors identify the initial and most important step in the treatment of this dysfunction to be physical demonstration to both partners of the existence of the involuntary vaginal spasm. Once this has been done, the husband initiates and conducts the actual dilation of the vaginal outlet, using Hegar dilators in graduated sizes, with the wife providing physical cooperation. The intention of the chapter on dyspareunia was to suggest to co-therapists that there are physiological as well as psychological causes for sexual inadequacy. In the treatment of primary and situational orgasmic dysfunction, the first authoritative directive in therapy is to suggest to the marital unit ways of developing a nondemanding and erotically stimulating atmosphere, one that will offer the woman an opportunity to spontaneously think and feel sexually. Verbal communication is encouraged throughout the 2 weeks; physical communication is introduced in progressive steps. After the couple and the co-therapists determine that the early return from sensate focus opportunity has been totally effective, the marital unit is encouraged to move on to the next phase in sensate pleasure. Each phase — genital manipulation, female superior coital position, and lateral coital position — is discussed in detail as are the specific instructions given to the couple. The authors identify the husband's role as vital to success in the treatment of orgasmic dysfunction. For the 193 patients treated for the presenting complaint of primary orgasmic dysfunction and the 149 treated for the presenting complaint of situational orgasmic dysfunction, they report immediate failure rates of 16.6 percent and 22.8 percent, respectively. In a separate chapter the authors provide a detailed presentation of their failure rates along with 5-year followup of their treated patients. Additionally, Masters and Johnson deal with the problem of sexual inadequacy in the aging male and female and conclude with a discussion of their treatment failures, reporting on limitations of concepts and technique and on methodological failures.

258.

McGovern, Kevin B.; Stewart, Rita C.; and LoPiccolo, Joseph. Secondary orgasmic dysfunction. I. Analysis and strategies for treatment. *Archives of Sexual Behavior*, 4(3):265-275, 1975.

The effects of treatment of six clients with primary orgasmic dysfunction and six clients with secondary orgasmic dysfunction were compared. In accord with the usual definitions of sexual disorder, none of the primary dysfunctional women had ever experienced orgasm through any mode of the physical stimulation before treatment, and all of the secondary dysfunctional women had experienced orgasm through masturbation but not regularly in coitus. The sexual treatment program was highly successful in altering the frequency of orgasm in primary dysfunctional women; it was unsuccessful in producing any change in the frequency of orgasm for the secondary dysfunctional women. No initial difference existed between the two client groups in their scores on the Sexual Interaction Inventory, which measures the desired frequency of sexual activities, desires for more pleasurable interactions, and the frequency with which partners' sexual preferences are misperceived. After treatment, there was still no difference between groups, though both groups had less maladaptive responses. Scores were also obtained from the Locke-Wallace Marital Adjustment Test. Measures obtained before therapy began revealed that there was no significant differences in these scores for the two groups of women. There was, however, a tendency for secondary dysfunctional women to be more dissatisfied with marital relations when compared with primary dysfunctional women. Before therapy, males in secondary dysfunctional couples were significantly ($p < .05$) less satisfied than were males in primary dysfunctional couples. At the end of the treatment periods, the primary dysfunctional women and the secondary dysfunctional couples reported a significant ($p < .05$) degree of improvement in their marital satisfaction. In attempting to explain their findings, the authors point out that therapy time with secondary dysfunctional women was spent on problems related to marital adjustment (e.g., basic communication skills); little time was spent on sexual behavior, so there was no improvement in that area among the secondary dysfunctional women. Another explanation for the continued inability for secondary dysfunctional women is that reliance on masturbatory behavior interfered with ability to reach orgasm through coitus. Two techniques are suggested to assist women in moving from a reliance on masturbation to reliance on coitus to reach orgasm.

259.

Meyer, Jon K.; Schmidt, Chester W.; Lucas, Mary Jane; and Smith, Elaine. Short-term treatment of sexual problems: Interim report. *American Journal of Psychiatry*, 132(2):172-176, 1975.

The authors report on treatment efforts with 16 highly selected white lower-middle to upper-middle class couples who requested help with a self-designated "primary" sexual problem from the Sexual Behaviors Consultation Clinic of Johns Hopkins University. The couples had been married for an average of 10 years; the age range was 23 to 52 for the men and 23 to 53 for the women. Problems in sexual satisfaction, often lack of orgasm in coitus, were the women's major complaint; performance inadequacies, usually impotence or inadequate ejaculatory control, were the major complaint for the men. Forty-four percent of the men and 87 percent of the women had sexual diagnoses; 75 percent of the men in contrast to 63 percent of the women had psychiatric diagnoses or symptoms or traits. The 16 couples were treated by two dual-sex teams of therapists. The Masters and Johnson format was followed except that 13 of the 16 couples were seen weekly rather than daily for a total of 10 or more sessions. When treatment ended, the therapists were available for telephone consultation at any time. The average personal posttreatment followup for all cases was 7 months. Judgments of treatment effectiveness were initially based on the couple as a unit, for the treatment approach identified the couple as the "patient." The authors report that 4 of the 16 couples, or 25 percent showed marked initial improvement — the primary sexual dysfunction in both partners was relieved. There was improvement for 25 percent of the couples, equivocal improvement for 31 percent, and no improvement or deterioration for 19 percent. At followup, three of the four couples with initial marked improvement and two of the four improved couples maintained their improved levels of functioning. In terms of individual outcome, 7 men and 14 women in the treatment group manifested sexual disabilities. Five of these men showed initial marked improvement, and three maintained this level at followup. Two men showed equivocal improvement, and, at followup, one man maintained equivocal improvement, and one man returned to a pretreatment level of functioning. Of the 14 women with sexual disability, 8 showed no initial improvement, constituting the major source of failure. Two showed initial marked improvement, one showed improvement, and three were rated equivocal. At followup two women with marked improvement maintained that level; the one individual who had improved, along with one woman from the equivocally improved group, dropped by a level. In their discussion, the authors comment on the high incidence of associated psychiatric problems they found in patients requesting treatment for common sexual difficulties. They indicate that in this series it was easier to achieve and maintain control with male performance problems than with female problems. There was also a tendency for higher degree of nonsexual psychopathology to be related to less initial improvement and poorer maintenance of that improvement at followup. Comparing their results to those of Masters and Johnson, the authors report that their failure rate for couples was almost equivalent but that their success rates for individuals were less positive. They identify the need to specify the degree of improvement among nonfailures for purposes of followup and later comparisons.

260.

Munjack, Dennis, and Kanno, Pamela. An overview of outcome on frigidity: Treatment effects and effectiveness. ***Comprehensive Psychiatry*****, 17(3):401-413, 1976.**

This article reviews reports of outcome achieved by varying approaches to the treatment of frigidity. The goal is to assess the present status of outcome research, determining which treatment modalities seem most effective and which lines of investigation appear to be most promising. Presented in tabular form is a five-page "Survey of Uncontrolled Studies on the Treatment of Frigidity (1950-1974)" which includes 20 studies. Two controlled studies of the treatment of frigidity are presented in a second table. Case reports are given from different therapy modes used to treat female sexual dysfunction. Four cases are presented in which psychoanalysis reportedly enabled nonorgasmic women to achieve vaginal or "vaginal-like" orgasms. Eight case studies are reviewed in which frigidity was successfully treated by behavior therapy (generally using some variation of systematic desensitization). In one case, group assertive training helped a frigid woman cure her inability to express anger and her role confusion; her frigidity was eliminated along with these other problems. In a second case, masturbatory training was used to successfully treat primary orgasmic dysfunction. A third case is described in which systematic desensitization followed by dynamic therapy provided an effective treatment for primary orgasmic dysfunction and negative reaction to coitus. Two successful cases of hypnotherapy are reported in which patients were enabled to be consciously aware of and express their anger so that normal sexual functioning was possible. In two other cases, psychotherapy and hypnosis were combined to treat anorgasmia. The work of Masters and Johnson in their 2-week training and reeducative program is noted. For 342 patients treated for orgasmic dysfunction, Masters and Johnson reported an initial failure rate of 19.3 percent and an overall failure rate of 20.8 percent. The authors indicate that the subjects in all the studies reviewed were white, middle-class women in their twenties or thirties who were suffering from sexual unresponsiveness with no organic cause and no outstanding psychiatric disorder. The methodological deficiencies of the studies included in the first table are presented in detail. The case reports indicate that combinations of behavioral, reeducative, and retraining procedures have been most commonly used, although other treatment approaches have also been used with success. The authors consider two studies, Obler (1973) and Wincze and Caird (1973), presented in the second table to be the best studies available to date, for they have come the closest to meeting the minimum criteria of treatment group, no treatment control, pretreatment assessment measures, posttreatment independent "blind" assessment, and adequate followup. Wincze and Caird (1973) treated 10 subjects with systematic desensitization and 11 subjects with video-desensitization in an attempt to bring about changes in anxiety associated with heterosexual activity as well as changes in general anxiety, fear, and assertiveness. At 1- to 3-month followup, 33 percent of the systematic desensitization couples reported improvement and 33 percent reported orgasmic occurrence; these figures were 90 percent and 60 percent, respectively, for the video-desensitization couples. On the basis of the evidence reviewed, the authors conclude that psychologic therapy is of some value in the treatment of female sexual dysfunction, with short-term behavioral treatment publishing most reports of success. They suggest that more systematic controlled investigation is needed.

261.

Pauly, Ira B. Female transsexualism: Part II. ***Archives of Sexual Behavior,*** **3(6):509-526, 1974.**

This article is based on data drawn from a review of the literature in which 80 cases of transsexualism were found. The focus is on the psychological and psychiatric evaluation, biological data, and treatment of females who want to become men. The author points out the limitations of this review throughout the text. He writes that in their psychological evaluations female transsexuals appear to be better adjusted than their male counterparts. They accepted the masculine role at the same period of gender identification when other females accepted the feminine role, and he suggests that given the forces operating on them, their preference for a masculine gender identity is both rational and understandable. Pauly distinguishes between gender disorders associated with psychosis and the longstanding gender-identity problem presented by the transsexual, for whom the request for a sex change is merely the final step in a process begun years before. Although most of the transsexuals studied were diagnosed as having personality disorders because their sexual behavior was considered deviant, the most prevalent psychopathology seen in these women was depression. Table 1 presents data on depression drawn from histories and psychiatric examination. In figure 2, the biological data on the 80 cases of transsexualism are summarized. The female transsexual is shown to be generally phenotypically and genotypically within normal limits. Although there has been speculation about abnormal findings in the electroencephalographic examinations of some transsexuals, Pauly reports that the etiology of transsexualism must be considered unknown. He refers the reader to part I of his discussion of female transsexualism for a sequence of events that may set the stage for transsexualism. It is noted that 96 percent of the patients considered in the literature had extensive psychiatric evaluation before any decision was made about treatment. In 93 percent of these cases the psychiatrist recommended testosterone and sex-reassignment therapy. Although the treatment has many critics, the vast majority of researchers have concluded that sex reassignment is the only available therapeutic modality. In figure 3, the surgical and hormonal treatment received by female transsexuals is shown. Fifty percent were treated with male hormones. Almost all who had undergone surgery had been previously treated with testosterone for at least 6 months with favorable emotional response. The author refers the reader to figures in part I of his discussion that show that the transsexuals had a mean lapse of 5 to 6 years between permanently taking up the male role and deciding to alter their anatomy. He points out that most physicians will not recommend surgery until initial steps like social passing and testosterone therapy have been maintained for at least 6 months. The patients' responses to surgical procedures, most commonly mastectomy and hysterectomy have been uniformly positive. The advantages of using a team approach for the treatment of transsexuals are pointed out, especially the insistence on long-term postoperative followups. A summary is provided that reviews both part I and part II of this discussion of female transsexualism. Pauly concludes that despite strides made in understanding and treating transsexualism, it would be far better prevented than treated.

262.

Philippopoulos, G.S. The analysis of a case of frigidity (psychopathology-psychodynamics). ***Psychotherapy Psychosomatics,*** **15(2-4):220-230, 1967.**

After briefly reporting on the history of knowledge relevant to frigidity and citing the views of such investigators as Freud, Kinsey, Deutsch, Menninger, McGuire, Heiman, and Glover, the author presents a psychoanalytic interpretation of a case of frigidity in a 28-year-old Greek woman. The patient, called Andromache, was seen by the author three or four times a week for 3½ years. Andromache's background is described in detail. In addition to being unable to achieve vaginal orgasm in relations with her husband, she suffered from attacks of anxiety, the urge to urinate during coitus, and occasional agoraphobia and ravenous hunger. The author discusses the transference process that occurred and reproduces material from the patient's free associations, dreams, and fantasies to reveal their characteristic nature, to demonstrate that they verify the Freudian view of frigidity, and to clarify the dynamics of the case. Philippopoulos reports that Andromache readily accepted his analysis of her dream and fantasy material and his Freudian interpretation of her anxiety attacks. He indicates that these interpretations, provided in the text, helped her to become emotionally stronger and more mature and strengthened her ego. As a result of the insight gained in analysis, Andromache rid herself of her neurotic symptoms and was able to have a normal sex life. She achieved vaginal orgasms often and never again masturbated as she had done previously to bring herself to clitoral orgasm. Part of a letter Andromache wrote to the author toward the end of her treatment is included to illustrate the quality of the transference relationship and the patient's acquired sense of security. Although Philippopoulos notes that not enough time has elapsed to objectively evaluate the outcome of the analysis, Ferenczi's standards that a woman conquer her masculinity complex and come to think of herself in terms of the feminine role are presented to suggest that the outcome of this analysis was both satisfactory and rewarding.

263.

Schneidman, Barbara, and McGuire, Linda. Group therapy for nonorgasmic women: Two age levels. ***Archives of Sexual Behavior,*** **5(3):239-247, 1976.**

The authors report on their study of a group method of therapy for the treatment of primary orgasmic dysfunction in two groups of women, 10 younger than 35 (group A) and 10 older than 35 (group B). The participants were randomly selected from a group of 35 women who had stable relationships with their partners. The instructions given to the subject and her partner in preparation for the study are presented. The short form of the Minnesota Multiphasic Personality Inventory, the Locke-Wallace Marital Adjustment Test (MAT), and the Sexual Responsiveness Survey were administered. Both groups A and B were composed of white, middle class, college educated couples who were within the normal range on the MMPI and whose MAT scores averaged 114 for the women and 117 for the men (group A) and 109 for the women and 108 for the men (group B). Four components of the group treatment program for the women are described: (1) educational and audiovisual instruction, (2) group discussion for the women, (3) couple-oriented therapy ("Masters and Johnson" style of behavioral therapy) to be practiced at home with partner, and (4) self-stimulation or training in masturbation. The program's success was determined by the ability of the women to achieve orgasm and by their attitude change. The latter was measured by the Marital Adjustment Test and the Sexual Responsiveness Survey. At the end of the 10-week treatment, 70 percent of the group A women reported that they were orgasmic with vibrator stimulation, masturbation, or partner stimulation, but none were orgasmic with intercourse. There was no change at the 3-month followup. At the 6-month followup, 80 percent of all group A women were orgasmic with vibrators, masturbation, or a vibrator used with intercourse. Of group B women, 40 percent were orgasmic at termination of therapy, but none were orgasmic with intercourse. The 3-month followup showed no change. At 6 months, 60 percent of the 10 women reported that they were orgasmic with vibrators, self-stimulation, or partner-related activities. One woman was orgasmic with intercourse 50 percent of the time. For group A, the Sexual Responsiveness Survey revealed seven couples with no change in areas of agreement or disagreement, and three couples who indicated that there was more agreement following treatment. In group B the survey showed 10 couples with no change in areas of disagreement or agreement. MAT scores were tabulated for the two groups and showed a significant positive change for the group A female partners. Indicating that the group method appears to be less successful for older women who may achieve better results in couple-oriented therapy, the authors conclude that the group treatment appears to be a highly effective method of changing patterns of sexual response. They point out that lack of attainment of coital orgasm did not seem to be a concern of these couples and note that there was such an obvious enhancement of sexual relations and communication techniques that coital orgasm was not a therapy goal. Most couples found that the sexual relationship continued to improve after therapy. The authors support their treatment approach for women only by indicating that the women group members were candid and supportive of other members' experiences and might have felt inhibited if men had been included.

264.

Segraves, R.T. Primary orgasmic dysfunction: Essential treatment components. ***Journal of Sex and Marital Therapy*****, 2(2):115-123, 1976.**

Segraves attempts to establish essential components of a successful sex therapy treatment regime for primary orgasmic dysfunction and to point out the areas that need clinical research. A brief review of the historical background of the new sex therapies is presented. The author notes that two independent schools, the behavior therapists and Masters and Johnson, arrived at similar conclusions about the etiology and treatment of sexual disorders. A literature review is presented with the treatment regimes divided into systematic desensitization studies (5), masturbatory training approaches (2), and the Reproductive Biology Research Foundation Series (1). These eight treatment studies are summarized in tabular form. Segraves points out that all the conclusions reached on the basis of these data must be considered tentative, because different screening procedures, definitions, and outcome criteria were used in each clinical series reviewed. All three treatment techniques combined with unspecified psychotherapeutic procedures are obtaining fairly successful outcomes. Since all the programs have proved valuable for the treatment of primary orgasmic dysfunction, Segraves suggests that it may be possible to identify the essential components of a successful treatment regime by determining what they all have in common. Segraves reports that each treatment mode employs some form of gradual exposure to sexual stimuli. The evidence also suggests that some form of social skills training or directive psychotherapy is necessary for successful treatment. Additionally, most of these programs emphasize learning to express one's affection and to assert wishes and desires. Based on these data, the question arises as to whether some of the marital interactional problems encountered in the Masters and Johnson treatment format might be avoided by using one of the behavioral approaches that focuses on single partner dysfunction. Segraves notes, however, that there are no clear-cut indications of when treatment with just one partner will suffice. The question is also posed as to what happens when a patient who is taken out of the marital relationship and treated successfully is returned to the marital system. The indications and contraindications for sex therapy also need to be determined, according to the author. In concluding, Segraves notes the pressing need for controlled clinical studies to differentiate the effectiveness of various procedures and identify the populations for whom these procedures are appropriate.

265.

Wallace, Douglas H., and Barbach, Lonnie Garfield. Preorgasmic group treatment. ***Journal of Sex and Marital Therapy*****, 1(2):146-154, 1974.**

An in-depth evaluation of a group treatment program for preorgasmic women is reported on in this paper. The analysis is based on 17 women—three groups of six women each (one woman discontinued therapy due to a death in her family) — who ranged in age from 19 to 34 years and whose educational and occupational backgrounds varied. Fourteen of the women were either married or involved in ongoing relationships. Several attitude and behavioral measures were completed by each subject before counseling began, at termination, and at 3 months posttermination: the Rosenberg Self-Esteem Scale, the Second-Jourard Body Acceptance Scale, the Locke-Wallace Marital Survey, the Attitude Toward Women Scale, and a questionnaire that focused on attitudes toward sexual behavior. An interview was also conducted before and at the end of counseling, and a telephone interview was held with each woman 8 months posttermination. The group sex counseling approach (Barbach, 1974) was used. It involves two women counselors working with a group of six preorgasmic women for 10 sessions over a 5-week period. Graduated "homeplay" exercises, such as self-exploration of one's body and masturbation, are assigned to the women. The authors report that each of the 17 women was orgasmic with masturbation by the end of the 10 sessions and continued to remain so after 8 months. Over 87 percent of the women related that they are now orgasmic in partner-related sexual activities; 68 percent are orgasmic more than 75 percent of the time. The pre-post comparison reveals that the changes in orgasmic capability that occurred are statistically significant. At termination the women indicated improvements in their general level of functioning, in their communication with their partner, and in their overall level of happiness and relaxation. While the "improvement in general" dimension decreased at the 8-month followup as compared with its immediate posttreatment rating, the other dimensions did not, and the sexual enjoyment dimension showed a marginal increase. Five individual items on the Attitude Toward Women Scale did change significantly in the expected direction, reflecting an increased awareness and assumption of equality in the relationship with the partner. Concomitant with increased feelings of equality was a significantly increased interest in politics. A number of body scale items are also reported to have changed significantly. The authors relate that increased happiness in the relationship with the partner correlated with increased importance of sex, enjoyment of sex, and sexual responsivity. The women enjoyed aspects of partner sex more as they experienced improvement in their sexual adjustment. As self-perceived sexual adjustment increases, the frequency of masturbation decreases. The authors indicate that this suggests that as a group the women tended to move away from masturbation as a means of achieving orgasm toward partner-involved sexual activities after counseling ended. Wallace and Barbach conclude, on the basis of the data they present, that the treatment of primary anorgasmy with group sex counseling techniques for the female partner only is both feasible and effective.

266.

Wincze, John P., and Caird, William K. The effects of systematic desensitization and video desensitization in the treatment of essential sexual dysfunction in women. ***Behavior Therapy*****, 7(3): 335-342, 1976.**

The authors evaluated two methods of treating frigidity in women. The first approach, systematic desensitization, involved exposing the women to pictures of people who were having sexual relations, and thereby reducing anxiety that the women reported when looking at the scenes. The second approach, video-desensitization, involved exposing the women to videotapes of people engaged in sexual activity. A control group was also established; subjects were told not to engage in sexual activity and did not receive any treatment. Each of the treatment groups was told to abstain from sexual activity during the course of the treatment. Subjects were 21 of 100 women referred. Although approximately 75 percent of the women reported lack of orgasm, their primary complaint was excessive sex-related anxiety and the inability to derive erotic pleasure. The 21 women were between 18 and 38 years old and were selected because (1) they exhibited "essential" rather than "situational" sex dysfunction; (2) their husbands agreed to be interviewed for the study; (3) they did not have psychotic-like behaviors; and (4) they did not have physical problems related to their dysfunction. The subjects were randomly assigned to one of the two treatment groups or to the control group. The control group subjects did not report any change in sexual adjustment between a pretest and posttest and were later assigned to treatments and considered as members of the two treatment groups. All subjects were given the following tests before and immediately after treatment: the Fear Survey Schedule, the Heterosexual Anxiety Scale, a Card Sort measure of anxiety, the Willoughby Scale (which measures neuroticism), and an Assertiveness Scale. Each woman and her husband was asked to complete a 5-point scale ranging from much improved to much worse sexual relations. Women were also questioned about their frequency of orgasm. The posttest items measuring improvement in sexual relations were repeated 3 months after treatment ended. Six of 10 subjects exposed to the systematic desensitization technique reported very much or much improvement in sexual functioning immediately after therapy. At the later followup, three of nine subjects exposed to systematic desensitization continued to report that level of improvement. Nine of the 10 subjects in the video-desensitization group reported very much or much improvement, and they continued to report that degree of improvement at followup. Tukey tests were carried out on the adjusted mean posttest scores for the Fear Survey Schedule, the Heterosexual Anxiety Scale, the Card Sort, the Willoughby Scale, and the Assertiveness Scale. The pretest scores were used as covariates to adjust the means. Tests were made of differences in before and after scores as well as differences in the posttest scores for the two treatment groups. Video-desensitization resulted in a difference in adjusted posttest scores on the Fear Survey Schedule ($p < .05$), whereas the systematic desensitization did not. Video-desensitization resulted in a lessening in anxiety as measured by the Heterosexual Anxiety Scale ($p < .05$); the control conditions did not. The Card Sort measure of anxiety revealed significant ($p < .05$) reduction in anxiety in the two treatment groups but not in the control group. There were no significant changes in any group on scores on the Willoughby Scale or the Assertiveness Scale. In interpreting their results, the authors suggest that the video-desensitization technique was generalized better by the women than the systematic desensitization technique.

Work Related

267.

Brooks, Linda. Supermoms shift gears: Re-entry women. *The Counseling Psychologist*, 6(2):33-37, 1976.

This article presents guidelines for counseling "re-entry" women — women who are going back to school or obtaining work outside the home. Concentration is on married middle-class women who have been primarily wives and mothers for a number of years. A framework has been established for assessment and intervention that views the re-entry process as a series of stages. These stages have been compiled by the author using Matthew's model for vocational counseling of adult women, career development theory, and her own experiences with re-entry women. The first three stages of the process are part of a preparatory phase. They are "vague discontent," "inner preparation," and "intensive family involvement." Each of these stages is defined and the counselor's role in helping the client work through them is described. The four final stages of "assessment," "generating alternatives," "narrowing alternatives," and, finally, "implementation and goal setting" are part of the decision phase and are also presented with suggestions for counseling. A section is provided which discusses the special problems women will face if they return to school — low self-confidence, time management, role conflict, and guilt — and presents suggested intervention for each. The preferred mode for assisting re-entry women is group counseling with specific objectives and structured activities and supplemented with individual sessions. Re-entry is best regarded as a normal transitional state and counselors should be able to intervene at whatever point help is sought. Outreach programs are a means of preventing transitional crises by encouraging women to meet in supportive groups. In conclusion, the author notes that counselors must be nonideological in order to be able to reach the greatest number of women, that they must not be prejudiced against client choices that retain traditional roles, and that they must realize that the depression and confusion felt by these re-entry women are not signs of neurosis but are caused by their situations and can be alleviated with reality-based counseling.

268.

Dewey, Cindy Rice. Vocational counseling with women: A nonsexist technique. In: Rawlings, Edna I., and Carter, Dianne K., eds. *Psychotherapy for Women: Treatment Toward Equality.* Springfield, Ill.: Charles C Thomas, Publisher, 1977. pp. 207-220.

Dewey presents the Nonsexist Vocational Card Sort (NSVCS), a structured interview technique she developed. She writes that traditional vocational counseling has contributed to the oppression of women by perpetuating sex stereotypes through counselor bias and the use of vocational inventories that have not been updated to reflect changes in attitudes toward sex roles. In order to meet women's needs, career counselors must change the theories, techniques, and materials they use. Women are caught between the dependent sex role they have been taught to accept and their need to develop and use their abilities. The goals of career counseling must be revised so that women can be assisted in clarifying their personal values while recognizing that decisions made on the basis of these values will change with continued growth. Women need to work through their feelings about competing with men and deal with the anxieties that come from choosing to oppose cultural expectations. According to Dewey, vocational counseling should shift from a testing approach to an approach that helps clients explore themselves in relation to their environment. Conflicts must be brought into focus and confronted. The NSVCS was developed as an alternative to traditional counseling. It stresses the client's involvement in exploring all aspects of her being in relation to personal growth and opportunities in work and leisure activities. A table of the 76 occupational categories it includes is presented along with a description of the NSVCS format. The card sorting process is described to the client as a way of helping her organize her thinking and talk about herself in relation to occupations. The sorting is done informally. The counselor records key words, values, or themes that emerge, and these are used in later counseling. The sorting process is described in detail. Based on her observations, the counselor directs discussions concerning the various groupings made by the client. The focus is primarily on the client's expressions of herself and her values and secondarily on the specific occupations in the NSVCS. A woman's internalized sex-role limitations can be confronted and worked through along with sex-typed biases about occupations. Dewey points out the importance of helping the client plan specific steps to follow in obtaining information about occupational areas to which she feels attracted. Three case studies illustrate how counseling using the NSVCS actually works. The author reports that the use of this technique has led to quicker identification of vocationally relevant topics for discussion than has the vocational interest inventory or the unstructured interview. She concludes that the NSVCS provides a new tool that offers an alternative to traditional vocational counseling at a time when the field is in crisis because of its failure to meet the needs of women. The process illuminates the conflicts, self-doubts, and strengths that must be dealt with if vocational counseling is to have meaning.

269.

Harmon, Lenore W. Career counseling for women. In: Rawlings, Edna I., and Carter, Dianne K., eds. *Psychotherapy for Women: Treatment Toward Equality*. Springfield, Ill.: Charles C Thomas, Publisher, 1977. pp. 197-206.

Although work can be a way for women to express their identity and explore potential for self-actualization, many women seem unable to make choices about work in their lives. The essential task of career counseling with women is identified as helping women to maximize their potential choice and control of their lives. Harmon discusses theories of career development and, on the basis of these, suggests that women give more consideration to external influences than men do in making career choices and that, to avoid conflict, women choose occupations from within the norm for their sex. In addressing the question of motivation to work, Harmon uses Maslow's hierarchy of needs — physiological, safety, belongingness and love, esteem, and self-actualization — to explain vocational behavior in a way that is useful in career counseling for women. Many women fill their physiological and safety needs by associating with a man; counselors have observed that women often do not believe that they can gratify these needs independently. Furthermore, women who venture outside the home to take jobs other than those reserved for women risk whatever feelings of belongingness, love, and esteem they get from fulfilling the prescribed feminine role. Harmon points out that although career counseling is generally geared to high-level gratifications, as posed by Maslow, most women are not ready for this kind of counseling. Only when a woman's physiology and safety needs are met and she has resolved conflicts over achievement and self-esteem is she free to make career plans that fulfill needs for self-actualization. Thus, in career counseling, counselors should assess a woman's developmental stage in relationship to Tiedman and O'Hara's (1963) decision-making stages. Additionally, they should determine the client's level on Maslow's hierarchy and how she got there. Harmon asserts that it is important for every woman to be able to independently meet her most basic needs. Women who know they can meet physiological and safety needs may still require counseling to work through conflicts over fulfilling their own needs and meeting the needs of others who are sources of love and esteem. According to Harmon, counselors generally are only prepared to deal with questions of self-actualization; they need to vary their techniques and learn to assess the hierarchical needs of women. Counselor bias toward women and careers is presented as a reality. The author suggests that counselors restructure their thinking and the materials they use in order to look at most careers and jobs as androgynous. She points out that the marriage-career dichotomy has been overemphasized; it was never a problem for men. In conclusion, Harmon states that clients must be helped to realize that their values may change. Counselors must provide their women clients with a model for future decision making so that they are prepared to live in a world of change.

270.

Jeghelian, Alice. Surviving sexism: Strategies and consequences. *Personnel and Guidance Journal*, 54(6):307-311, 1976.

Based on her clinical observations as a psychologist and her experience as an affirmative action officer, Jeghelian focuses on the problems of women who choose to confront sexism. She points out that the women who follow this course of action continue to be a minority. Nevertheless, they are emerging as a potential client population for counselors and therapists. Women who confront sexism experience new and painful kinds of stress and exhibit a common symptomatology. They express tremendous anxiety and conflict about seeking assistance; consider "taking some action" as comparable to going to the Supreme Court; feel hurt and angry as well as fearful and reluctant to act in relation to the preceived injustice; and are often secretly hopeful that the helper will go out and correct the situation without getting them personally involved. A composite case is presented to illustrate some of the complaints presented. Common problems are described and suggestions are given for counseling at different points in the process of confronting sexism. At the stage of pregrievance counseling, the helper's goal is to enable the woman to recognize and separate "fact" from "fuming," helping her plan a course of action, and providing backup and support during such action. The conditions that have aroused the reactions are examined and evaluated and the options pointed out. Most women choose to confront their boss and try to work things out for themselves at that level. In the next stage, dealing with the confrontation and its consequences, the woman needs help in planning strategies, preparation for the very real possibility that she will be unsuccessful in this approach, and to be reminded that the alternative of the internal complaint procedure is still open to her. The consequences of her confrontation may be increased stress and frustration, isolation, and sometimes outright harassment. All women face the prospect of even greater tension and stress once they have filed a complaint. The institutional reaction to the woman's complaint is discussed, and the need for a very forceful approach in dealing with the institution is identified. In the final stage of postcomplaint fallout, the woman can have won her case—whether by personal confrontation, internal grievance procedures, or external suit — but, in all probability, she will continue to encounter institutional sexism in various guises. The emotional tensions of the past continue and are frequently exacerbated. In her concluding remarks, Jeghelian relates that if professional help is sought, the counselor needs to know something about the equal opportunity statutes that protect a woman's rights to employment and education. The counselor should also be able to suggest strategies for responding to the institutional sexism that often camouflages a violation of these statutes.

271.

Katz, Judith K., and Knapp, Nancy H. Housewife, mother, other: Needs and helpers. *Personnel and Guidance Journal*, 53(2):105-109, 1974.

The focus in this article is on middle-class housewives who, as a result of the women's movement, want to expand their horizons. The majority of these women have not been radicalized; they merely hope to find personal fulfillment in meaningful employment outside their homes. The authors suggest that the opening of new options for these women, who previously accepted society's role expectation for them as dutiful wives and mothers, often creates confusion and mild depression, as well as role conflict and an undermining of self-confidence. The people in their immediate environment often cannot help these women deal with their new feelings. Psychotherapy is seen as too traditional for them, and consciousness-raising groups as too radical and disruptive. According to the authors, these women need help in sorting through their options and setting goals. They need advice on how to combine family and career. Many new agencies have been created to help these women, and they are usually not associated either with traditional counseling agencies or the women's movement. Examples are given of a couple of these agencies and how they function. They generally offer reality-based therapy and encourage realistic self-appraisal and goal setting. The group counseling they offer is identified as very valuable in letting women know they are not alone in wanting to alter their traditional lifestyles. Expected roles and behavior are redefined, and the women find identification with a new group of peers. Although these agencies have been very effective in helping women combine family and career, the authors suggest that they need professional assistance in evaluating their programs and should be aware of professionals to whom they can refer women who need more assistance than they offer. At the same time, they note that professional counselors should be aware of these agencies and the valuable intervention they can provide for women who wish to seek lives outside their homes.

272.

Manis, Laura G., and Mochizuki, June. Search for fulfillment: A program for adult women. *Personnel and Guidance Journal*, 50(7):594-599, 1972.

This article describes a workshop program established in 1970 by the Western Michigan University Counseling Center to deal with the needs of housewives who want to continue their education or enter the job world. The objective of the first phase of the program is to remove the psychological blocks that prevent women from making decisions necessary to changing their lives. The second phase allows participants to assess their own abilities as well as available opportunities in the community. Generally, participants are middle income women in their middle to late thirties who have two or three children. They have the same problems that other studies have identified for women in this situation—role conflict, feelings of low self-worth, loneliness, lack of goals, guilt, dependency, and depression, as well as fear of decision making and risk taking. Work experience before becoming housewives was limited to jobs such as nursing, secretarial work, or teaching — socially approved jobs for women that were thought of as stopgaps until marriage. Each workshop group, led by two facilitators, was divided into six small groups of six women. Activities included group interaction, testing, and homework assignments. The following five program goals are described in some detail as are the major activities and exercises designed to meet these goals: (1) trust building, giving support, sharing concern, relieving guilt, and learning to work in groups; (2) learning to communicate and improve interpersonal relations; (3) building self-confidence and reaching an understanding of oneself and one's abilities; (4) learning to be responsible, to make decisions, and to take risks; and (5) learning about available opportunities that exist in the outside world. Two weeks after the final group meeting, each woman has a 1-hour individual counseling interview to deal with any specific problems. A questionnaire used to evaluate the program demonstrates its success in providing support, decreasing isolation, sharing concerns, and improving interpersonal relations. The program has also been helpful in terms of goal setting and creating the impetus for taking the first step to reenter the outside world.

273.

Messer, Stanley B., and Lehrer, Paul M. Short-term groups with female welfare clients in a job-training program. *Professional Psychology*, 7(3):352-358, 1976.

This article describes the authors' experience in leading short-term groups (six 2-hour sessions) with female welfare clients in a job training program (Work Incentive Program, WIN). The modal program participant is a 28-year-old mother of three children who is separated from her husband and has 9.5 years of education. The group was developed in recognition of the fact that emotional problems commonly affect the ability of enrollees to obtain and keep a job. The authors report that most of the enrollees are willing to self-disclose in these groups and to engage in active and meaningful group process. They identify the reasons for the women's active involvement in the group, pinpointing temporary respite from overwhelming daily problems as the primary reason. Some of the dominant problems and themes presented by the women during group sessions are discussed: anger at the men in their lives; violence as a regular occurrence; effects on their children of living in a broken home and their children's emotional and behavioral problems; and reactions to the role of welfare recipient. The goals of the group are identified and elaborated upon: (1) recognizing individuals who need and can benefit from more extensive professional treatment for emotional problems; (2) brief treatment for emotional problems; (3) educating the group members by example regarding what mental health professionals can do; and (4) providing factual information about a variety of topics including child-rearing practices, sex, and emotional disorders. According to the authors, the women benefited from simply talking about their problems with other women who had had similar experiences. The women also learned from each other's strategies for dealing with the welfare establishment and violent boyfriends. The knowledge that their problems were shared by a supportive group of other persons was also reassuring. Finally, the group both sought and offered feedback and perspective that helped members begin a process of self-examination, enabling them to perceive their problems in a new way. The authors conclude from their experience with the WIN program that the treatment of the emotional problems of very low income persons should have a two-fold focus: (1) providing assistance with the real problems of economic survival through social and vocational rehabilitation; and (2) offering psychotherapy to help with the emotional conflicts and maladaptive behavior. They identify a job training program as an opportune and effective setting for the beginning of mental health treatment, because it provides a context in which individuals can develop realistic hope for an improved future.

274.

Pendergrass, Virginia E.; Kimmel, Ellen; Joesting, Joan; Petersen, Joyce; and Bush, Endilee. Sex discrimination counseling. *American Psychologist*, 31(1):36-46, 1976.

In an article focusing on the counseling of women who protest sex discrimination, the authors discuss the possible courses of action open to such women. They present their concerns in five separate sections: friendly little chats; academic women and unions; legal suits; personal counseling during discrimination actions; and sex discrimination—special problems of black women. The stages of the friendly little chat—an informal activity engaged in by women before a formal grievance suit—are described in detail: recognition of the problem and decision to act; preparation; holding the chat; the institution's response; countermoves; and success and failure. In a discussion of academic women and unions, information about now unions can and cannot help women is provided. The author suggests that when the grievance procedure has been exhausted, the complainant may turn either to local or State laws prohibiting sex discrimination or to Federal legislation. Federal legislation that protects women from sex discrimination in employment is reviewed. Focus is next on the personal counseling of women during discrimination actions. An example is provided of a woman who was referred to one of the authors, Pendergrass, for counseling. The course of this client's employment problem and her battle is presented. Describing the woman's extremely distraught state, Pendergrass makes the point that a woman who comes for counseling, may appear unstable, leading the counselor to suspect that she may have caused some of her own job problems. On the basis of her experience, Pendergrass suggests that a woman who complains of job discrimination has probably experienced job discrimination. Additionally, she often has an excellent work history, has had discrimination rubbed in, has tried to alter the situation in a nice way, and has finally become angry. In discrimination counseling, a woman needs to be believed, to be encouraged, and to be trusted. The counselor may be most helpful when she trusts the client to make the best decision possible under difficult circumstances. The authors outline and discuss other problems that are likely to emerge in counseling: (1) handling requests for legal advice or strategy; (2) alleviating depression and anxiety about the value of the woman's work skills and future employment; (3) advising women who have a poor suit but wish to sue and those who have a good suit but choose not to sue; and (4) fulfilling needs for companionship. In the final discussion of the article, the special problems of black women, attention is on the black woman's isolation in the black community as well as her isolation from white women. It is pointed out that the process of protest is the loneliest for the black woman. The black woman needs to select rational strategies for the elimination of both racism and sexism and to put aside blame and unforgiveness. The white woman needs to respond by recognizing the double burden of the black woman who must be given extra understanding and support during discrimination actions.

275.

Pincus, Cynthia; Radding, Natalie; and Lawrence, Roberta. A professional counseling service for women. *Social Work*, 19(2): 187-195, 1974.

A study at a counseling center for women on the campus of a large Northeastern university explored the clients' situations and the types of service that would help them. The center offered counseling services with a psychiatric social worker; information on career development, employment, and education; and symposiums and group discussions on combining roles, re-entry to work and study, and career decisions. Emphasis was on the woman's interests and needs, and staff members were sympathetic and supportive. The study was conducted during a 6-month period in the fall and winter of 1971 and included all applicants except those referred by psychiatrists. Sociodemographic data on 98 applicants and more detailed information on a sample of 46 applicants were collected. Clients were predominantly white, under 30 years of age, from social classes 1 and 2 (Hollingshead, Two Factor Index of Social Position, 1957), and well educated — more than 50 percent had some graduate education and only 1 percent had not continued beyond high school. Over 95 percent of the women wanted more information about employment, and 87 percent were unemployed at the time of the application. Data on clinical status were obtained by two independent interviewers. One interviewer administered a brief screening questionnaire that assessed symptoms of depression on the sample of 46 applicants. Independently, the second interviewer, a psychiatric social worker, interviewed these women to obtain information on recent life events, work history, health, treatment status, and attitudes. At the initial interview, 18 of the 46 women in the sample group scored 6 or over on the Raskin 3-Area Scale of Depression (range 3-15) and were considered to have moderate to severe symptoms of depression. Most of the women indicated a desire for full- or part-time work but were frustrated by a lack of available jobs, roles relating to children and marriage, and relocation. The major cause of their disrupted careers had been several moves in the previous 5 years; their husbands' careers had been responsible for almost all of these moves. One significant difference that emerged when the high symptom and nonsymptom groups were compared on a number of variables was the greater likelihood of the symptom group's having to relocate again in the next 5 years. All 18 women in the symptom group had a number of in-person and telephone contacts with the center during the 4-month period between the initial interview and the followup study. In these contacts most of the women received career-related counseling help. They also sought practical information about career and educational opportunities, child care, and domestic help. At followup, the 18 women in the symptom group showed clinical improvement as reflected in lower Raskin scores for overall degree of depression. Additionally, they revealed less pessimism and depression, less irritability, and more energy. Their scores measuring social adjustment were also improved. The authors report that the women were more effective and reliable in work performance, and that all but 1 of the 18 women were working or studying at the time of followup.

276.

Schlossberg, Nancy K. A framework for counseling women. *Personnel and Guidance Journal*, 51(2):137-143, 1972.

Schlossberg suggests that counselors who combine counseling, guidance, and social activism can help women to implement decisions and to realize their dreams. A decisionmaking paradigm developed by Tiedeman and O'Hara forms the basis for the counseling and guidance work Schlossberg suggests. Decisions are identified as having two stages—anticipation and implementation. The counselor's first task is to expand the parameters of the anticipatory stage for women so that sex-role stereotyping will not limit consideration of work choices. Her second task is to help change the social context so that the new broader possibilities can actually be implemented. Schlossberg explains that the Tiedeman-O'Hara paradigm can also be used as a framework for intervention by determining the woman's stage in the decision-making process. Once a woman develops a sense of herself by working through the anticipatory phase, she must move on to implement her new-found identity. The success of Oakland University's Investigation into Identity Program exemplifies how women can be aided by this process. Schlossberg believes counselors must help women to raise their consciousness and not accept the limitations society has placed on them. The goal is to free people to act in ways appropriate to their values and interests rather than their sex. The decisionmaking paradigm can also provide a basis for developing guidance programs—the expectation being that the most effective programs will be those with activities that facilitate both aspects of the decisionmaking process. According to the author, counselors have a responsibility to go beyond career counseling and into social activism. It is not sufficient for counselors to help people make fully human decisions if there is no possibility for implementing them. Several examples are given of how counselors can be involved in bringing about social change. A chart illustrates how counselors can use the two phases of the decisionmaking process in counseling, guidance programming, and social activism.

277.

Wells, Theodora. Up the management ladder. In: Rawlings, Edna I., and Carter, Dianne, K., eds. *Psychotherapy for Women: Treatment Toward Equality.* Springfield, Ill.: Charles C Thomas, Publisher, 1977. pp. 221-249.

This chapter focuses on the difficulties therapists' own sex-role values may pose in their work with career women. A case is presented in which a client seeks help because of being passed over for promotion, and readers are asked to note down their responses to the material as a way of working with their own values and views as therapists. Wells expresses concern that therapists may be out of touch with large organizations. Consequently, they may fail to realize that a woman who has become committed to her work is stepping out of traditional sex-role expectations and may be seeking help because of internal conflict. Pointing out that such a woman will be greatly affected by the therapist's reaction to her role departure, Wells suggests that it is necessary for the therapist to understand how sex-role expectations affect career women in work organizations. Miller and Mothner's (1971) work on the psychological dynamics of inequality is used to explain the psychological consequences of inequality. Indicating that sex roles are pervasive and institutionalized, Wells notes that recent research reveals some change. A description is given of how the male and female roles intermesh and reinforce each other, with the man always having more power. Wells suggests that therapists who work with career women must have an awareness of the values, dynamics, and games that permeate large organizations. She modifies Likert's (1967) four-system model to reflect women's potential within these systems and indicates that, according to Likert, most large organizations function paternalistically. An organization profile illustrating Likert's four systems is presented. Wells notes that in this kind of system women get intensive mixed messages about their worth. She discusses the overt/covert power dynamics of the paternalistic system, adding that women involved in such a system may doubt their own perceptions since covert discrimination is difficult to prove. Wells suggests that both male and female therapists may have difficulty dealing with career women because of the effects of their socialization. She asserts that therapists who are not aware of their own sex-role prejudices can psychologically maim such a client by being unable to see that she is responding to covert realities in her life and is trying to grow rather than exhibiting an abnormality. Wells provides a list of 20 values, ideas, and concepts which she believes can provide a therapeutic atmosphere in which the interests of the career woman client can be served. Among other things these are concerned with honesty and self-examination on the counselor's part, dealing with the client as an equal, and accepting the client as a credible adult whose perceptions and feelings are to be trusted. Wells suggests that to test whether their values differ for men or women, therapists imagine the female client is a man. The case presented in the beginning of the chapter is restated with the client as a man so that readers can test themselves.

Other

278.

Angrist, Shirley S.; Lefton, Mark; Dinitz, Simon; and Pasamanick, Benjamin. *Women After Treatment. A Study of Former Mental Patients and Their Normal Neighbors.* New York: Appleton-Century-Crofts, 1968. 333 pp.

The authors investigated the usefulness of short-term psychiatric hospitalization for mentally ill women in terms of socioenvironmental and psychological variables. Three aspects of outcome were assessed: patients' ability to remain in the community, their performance levels, and adequacy of performance levels compared to a control group of normal women. Evaluations were done in terms of customary roles of women, e.g., mother, neighbor, and housewife. Subjects were 287 former patients of the Columbus Psychiatric Institute and Hospital, a short-term intensive treatment, training, and research center. Most patients were white, Protestant, married, lower or middle class, with diagnoses of psychoses or psychoneuroses (a small proportion had organic diagnoses). Controls were 157 women who lived in close proximity to the former patients and had no psychiatric illness. Domestic performance, social participation, and psychological functioning were the three measures used to assess posthospital performance 6 months and 18 months after discharge. If a patient was unable to perform or if she needed help with routine household and child-care tasks, she received a lower score than if she managed entirely independently. Social participation was a composite measure derived by judging the patient in terms of her significant other; both leisure activities and interpersonal behavior were included. Psychological functioning included a list of 32 items which described behavior symptomatic of impaired functioning; the more symptoms a patient manifested, either sometimes or often, the lower her score. A total performance index — high, moderate, and low level performance — was also developed on the basis of the three major performance aspects. Additionally, structured interviews were conducted with subjects, controls, and significant others (usually husbands). The authors report that former patients performed less well than controls, particularly in domestic and psychological areas. However, the matched groups of neighbors and former patients showed the same patterns of relationships on attitudinal variables. For both groups of women, high role expectations were held for the high level performers, and low tolerance of deviant behavior was characteristic of the significant others of high performers. The authors indicate that despite these associations they concluded that the expectations and tolerance levels could not be considered as determinants of posthospital performance, for they may be reflective of actual performance abilities. Individuals who were not readmitted during the 7-year period performed better than rehospitalized patients, particularly in psychological functioning. Diagnosis was significantly related to posthospital performance, with highest performance shown by psychoneurotics and women with characterological disorders, and lowest by those with organic diseases. Marital status was the only significant social variable — performance was better in married women. The highest proportion of readmission occurred within 6 months (15 percent of the subjects) and then declined — 32 percent had been hospitalized at the end of the 7-year followup. Psychological problems were the only significant predictors of readmission. Again, there was no significant effect of excessively high expectations or low tolerance for deviance. Early returnees had wider ranges of symptoms and more often had organic diagnoses; later returnees had episodic illness patterns and generally higher levels of functioning. Social performance was poor for early returnees and fairly good for late returnees. The authors suggest that educational and marital status and familial factors may in fact bear significantly on mental illness — initially in terms of selection and later in terms of outcome.

279.

Bruch, Hilde. Perils of behavior modification in treatment of anorexia nervosa. ***Journal of the American Medical Association*****, 230(10):1419-1422, 1974.**

Bruch reports on the damaging aftereffects of treating anorexia nervosa with behavior modification programs. The information presented is based on the study of nine patients whose treatment with behavior modification had destructive results, and on consultations with over 50 patients with seemingly unmanageable anorexia nervosa. Three cases illustrate the negative effects of behavior modification. Charts show how the patients' weight increased under this treatment only to decline after their release. Bruch points out that this kind of weight gain is only beneficial when it is part of an integrated treatment program that corrects underlying individual and family problems. She sees the very efficiency of behavior modification as being psychologically damaging. Patients' inner turmoil is exacerbated because they feel that they have been tricked into giving up control over their own bodies. Bruch indicates that a feeling of ineffectiveness is one of the root problems in the development of anorexia nervosa. Under behavior modification patients feel trapped and forced to choose between two options that are unacceptable to them. Their self-esteem is undermined and their hopes of achieving autonomy and self-determination are destroyed. The patients seen by the author described their experiences with behavior modification as brutal and coercive and considered the treatment antitherapeutic. Bruch reports that new symptoms often appear after hospital release, such as binge eating accompanied by vomiting and/or sleep reversals. Patients felt that their psychological plight, i.e. depression, was completely disregarded. Bruch suggests that this inattention to the patient's overall deterioration (if weight is being gained) may be due to the fact that behavior therapy is recommended as a method that can be applied by nonmedical personnel who may have no understanding of anorexia nervosa as a complex illness. She points out that although anorexia nervosa is a dangerous disease, enforced weight gain may increase dangers by increasing the patient's sense of helplessness and precipitating preoccupations. Bruch discusses the existence of similar cases to support her claim that the cases studied for this report are not unusual. She asserts that until behavior therapists present long-term followup studies, her findings represent the only factual data on the long-range results of treating anorexia nervosa with behavior modification. She acknowledges that this treatment may prove effective in certain mild cases but concludes that it is a menace for patients with severe psychological problems.

280.

Flack, Ruth, and Grayer, Elinor D. A consciousness-raising group for obese women. *Social Work*, 20(6):484-487, 1975.

Flack and Grayer discuss the consciousness-raising approach they used with three groups of obese women. Recognizing that obese individuals are stigmatized in this society, they explain their choice to intervene with the low self-esteem of obese women rather than focus on the social value that "fat is bad." The authors state the groups' objectives as follows: (1) to clarify what it is like to be fat in this thin society; (2) to raise self-esteem by providing an accepting environment; (3) to lessen self-punishment; (4) to facilitate the women's recognition that to be fat is one of many choices an individual may legitimately make for herself; and (5) to help each woman realize and accept her choice and its inherent consequences. Before beginning, the therapists outlined these goals to the groups of women, emphasizing that this was not a weight loss group and that the therapists would not be concerned with weight gain or loss. The authors describe the course of the consciousness-raising group sessions, noting that throughout the weekly meetings the women experienced difficulty in dealing with the fact that this was not a weight loss group and with the therapists' neutrality about their weight. The women reviewed their histories as fat women, discussing feelings of resentment at not being unconditionally accepted and the effects of their obesity on relationships with men. All the women equated fat with being unacceptable and postponed all pleasures for the day they became thin. None of the women felt she deserved to enjoy the foods she ate, and many would not allow themselves to become angry, refuse demands, or assert themselves in their own behalf. The authors include a "Rules for Fat People" list which the women developed and which illustrates the special set of responses to their situation that the women learned. The authors were struck by the commonality in all three groups. Each group became more strongly and quickly cohesive than any other groups in their experience, and the women were warmly supportive of one another. The three groups of women shared three major characteristics: they did not consider their obesity a choice; they incorporated the culture's disgust with fat, recognized their status as a social deviant, and developed behaviors to cope with it; and they were capable of becoming self-accepting and less self-punitive in the right environment and could begin to make a choice about their weight. The therapists conclude that the groups were of positive value on the basis of their own clinical evaluation of the women's behavior, reports from the women's primary therapists (two groups were ancillary to ongoing therapy in a mental health clinic), and contacts with the women after the groups ended.

281.

Fodor, Iris Goldstein. The phobic syndrome in women: Implications for treatment. In: Franks, Violet, and Burtle, Vasanti, eds. ***Women in Therapy: New Therapies for a Changing Society.*** **New York: Brunner/Mazel, 1974. pp. 132-168.**

The hypothesis that phobic syndromes, particularly agoraphobia, are related to sex-role conflicts is explored. Suggestions for treating this and related phobias are given. Data are presented on frequency, sex incidence, onset age, and response to treatment for these phobias, and it is established that animal phobia and agoraphobia are overwhelmingly phobias of women. Fodor states that research reveals phobic syndromes to coexist with personality patterns of dependency and avoidance and overprotected childhoods. Research also indicates that a pattern of parental reinforcement, childhood learning, and socialization may provide clues to understanding phobic symptoms and their associated personality traits in women. This pattern, in particular, may shed light on women's propensity for developing agoraphobia—the most constricting syndrome. Fodor asserts that this phobic syndrome is similar to descriptions of stereotypic feminine behavior, with its helplessness, avoidance of mastery experiences, and lack of assertiveness. In the socialization process, dependency is reinforced in girls by parental sex-role expectations as well as by schools and the media. In adolescence, when identity develops, girls are encouraged to remain dependent and fearful. Women are unprepared for the realistic responsibilities of marriage and maintaining autonomy within a relationship. The idea is explored that the development of agoraphobia, which can be viewed as an exaggeration of the stereotypic feminine role, is related to a feeling of being trapped as in a marriage. Agoraphobia may provide a way to get out of the struggle between society's sex-role expectations and one's own feelings. Fodor then discusses the two major treatment approaches to phobia — the psychoanalytic and the behavioral. This is followed by a presentation of a behavioral therapy treatment model developed to deal specifically with agoraphobia. The supportive role of the therapist in reinforcing initiative and autonomy is discussed along with the need for behavioral diagnosis, desensitization to deal with the specific phobia symptoms, and expanded desensitization to cope with more general fears. Fodor states that the goal of treatment is not to get rid of the phobic symptom but to alter a dependent-avoidance way of acting, and she presents behavior rehearsal as a useful technique. Group therapy is helpful in showing agoraphobic women that they are not alone in their struggle for liberation and in providing reinforcement for change. Modeling is also helpful, and a female therapist can show her patients that it is possible to be comfortable as well as independent, assertive, and feminine. Work with the families of agoraphobics is vital, since the family's assistance is necessary for the maintenance of agoraphobia. Other fears, such as fear of success, can be treated similarly, since they may also reflect problems with autonomy. Fodor identifies women's greatest problem as overcoming their dependency. She recommends the establishment of short-term desensitization programs to help women overcome their childhood fears. In conclusion, the ways in which behavior therapy can help women facilitate sex-role integration and thus eliminate phobic symptoms are itemized.

282.

Geller, Jeffrey L. Treatment of anorexia nervosa by the integration of behavior therapy and psychotherapy. *Psychotherapy and Psychosomatics*, 26(3):167-177, 1975.

Geller presents a treatment plan for anorexia nervosa. The plan integrates behavior therapy with psychotherapy in order to simultaneously deal with both the underlying psychological problems and the eating disorder that constitute the syndrome. After discussing the similarities between behavior therapy and psychotherapy, Geller concludes that they have a common interface that allows for integration. This integration is identified as pragmatically suited for treating patients with anorexia nervosa — they need direct and immediate modification of their noneating behavior, and they need to explore the thoughts and feelings that generate a disturbance in their identity. Using Bruch's characterization of anorexia nervosa, Geller identifies the anorexia patient as one who needs to be reeducated to see herself with a minimum of distortion, to perceive hunger and satiety, and to achieve autonomy. The integrated model gives the patient an opportunity to exercise a high degree of autonomy within the framework of the reward system; gaining weight is the patient's own responsibility. The psychotherapy allows the patient to examine her reactions to her relearned eating patterns, to explore further possibilities of self-initiated behavior, to recognize her needs and make decisions based on them, and to discuss her awakening self-awareness. The psychotherapist also administers the behavior modification program, and Geller suggests that initially the therapy will be largely responses to this program. The intention of the therapist taking charge of the conditioning is to help the patient realize that persons connected with eating need not [illegible]tructive or invasive. In this integrated process, distortion of [illegible]onal needs is dealt with by a structured program of weight gain. The patient's sense of ineffectiveness is dealt with by establishing a task through the operant conditioning approach with a high degree of success. As the patient succeeds, she will develop a sense of mastery that will encourage her to continue to define manageable problems and seek their solutions. The patient's distorted self-image is examined in psychotherapy with data from her experience with the conditioning procedures. A detailed account is given of the treatment of a case of anorexia nervosa using this integrated model. The patient is described fully as is the progress of the treatment program. The behavior modification design, in which weight gain was rewarded by freedom to leave the ward, is detailed. Psychotherapy consisted of unstructured 45-minute meetings 5 days a week. The patient was hospitalized for 40 days and was released when she appeared to be both physically and psychologically sound. At a 1-year followup she was still healthy. Geller concludes that this integrated treatment plan produces weight gain as effectively as any technique while allowing the patient to work on ego defects at the same time. He suggests that psychotherapy concurrent with behavior therapy should be shorter and more effective than therapy begun after weight gain is a fact.

283.

Hill, Delcie E.C. Outpatient management of passive-dependent women. *Hospital and Community Psychiatry*, 21(12):402-405, 1970.

This article is based on a study of 50 passive-dependent women. The objective was to determine the personality and functioning of these women, the dynamics of their illness, and the therapy approaches that seem responsible for their improvement. The study was inspired by the author's success as a nurse working in individual outpatient sessions with passive-dependent women who had been unresponsive to conventional treatment from male social workers and psychiatrists. Hill discusses the common qualities found among these women, which included the following: never gaining any independence from their parents; no separate identity; demonstrated qualities of poor ego integration, such as insecurity, inadequacy, low self-esteem, and indecisiveness; inability to form close meaningful relationships; expressing and doing what they determined was expected of them; and, consequently, feeling hostile toward the controlling world, and suffering from many physical symptoms that provided a means of getting attention. According to Hill, they were "miserable people" who had no understanding that they could have control over their misery. She defines the ultimate goal of a treatment program for these women as helping each patient achieve her best potential of independent functioning and discusses the course of therapy with them. First a therapeutic relationship is established. The nurse conveys to the woman that she sincerely understands the reality of her misery, that she believes the patient does not have to feel that way, and that therapy can help her lead a more satisfying life. Some dependency is allowed initially. In the second phase of therapy, the patient is helped to resolve her problems, to learn more satisfying ways of living, and to realize that she has the responsibility for her own improvement. Hill elaborates upon the four lessons that are worked through during this part of the therapy: increasing feelings of self-worth, learning to express feelings and ideas, becoming comfortable making decisions based on one's own feelings, and learning to experience pleasure as well as to deal with panic. The final stage of therapy occurs when the patient has reached a functioning level that approaches her potential. Hill reports that this type of therapy proved very successful in helping passive-dependent women. Only 2 of the 50 women involved did not reveal some improvement. Believing that one can only conjecture about the factors responsible for the success of individual sessions with a nurse therapist, she suggests the following possibilities: the therapist was a woman and some transference occurred; a nurse therapist represents less authority than other professionals; or there was some personal attribute of this particular therapist.

284.

Houck, John H. The intractable female patient. *American Journal of Psychiatry*, 129(1):27-31, 1972.

Houck suggests that hospital treatment sometimes aggravates illness in a specific kind of intractable female patient. As a group, these patients best fit the category of "borderline syndrome" and their primary presenting symptoms are chronic depression and anxiety. Houck describes other associated symptoms and history, pointing out that the husbands of these patients tend to be passive, indulgent, and easily dominated and that child rearing is usually the stress that brings the women to the hospital. The patients are characterized as immature, anxious, angry, aloof from other women, and suspicious of men. Their initial treatment is usually psychotherapy, with tranquilizers often proposed as a secondary approach. Reviewing the course of treatment, Houck relates that it usually begins auspiciously but, then, for no apparent reason, crises occur, and the patient appears to take pleasure in the therapist's inability to help her. He notes that these young, intelligent, articulate, psychiatrically sophisticated, and well-motivated women were initially perceived as "good" patients, the kind of patient with whom therapists, particularly young residents, want to work. Houck goes on to suggest that as a consequence, therapists are unable to realize for some time that treatment has reached an impasse. This impasse in treatment seems to stem at least partially from secondary gains the patient derives from staying in the hospital and being relieved of home and family responsibilities. Other factors that contribute to this impasse are discussed. Houck writes that the impasse is usually only overcome by drastic measures — the husband filing for divorce, for example — that therapists would ordinarily associate with the therapeutic setback. This fact appears to suggest that in some cases the therapist's concern must extend beyond the patient to an attack on the woman's environment; some patients will not progress until life forces them to do so. On this basis, Houck proposes that hospital treatment for these women should be based on the recognition of critical realities: hospital stays should be comparatively brief; therapy should be supportive and aggressively oriented; and the patient's attention should be firmly fixed on her home, family, and adult obligations. Houck also suggests that early and aggressive efforts should be made to work with the patient's husband who is identified as the key to her rehabilitation. He believes that the wife will be helped if her husband is able to assume a posture of strength and resolution toward her. Pointing out that these women will usually not want to leave the hospital, Houck discusses how to deal with the possibility that posthospital problems might cause their return. He concludes that finally, with firm responses from her husband, the woman will realize that she does not want to win when she tests him, and she will be reassured and comforted.

285.

Kaplan, Lillian P. Some observations from conjoint individual and group therapy with obese women. ***International Journal of Group Psychotherapy*, 16(3):357-366, 1966.**

Results of the first 15 months of ongoing group therapy, in conjunction with individual treatment, with five obese Jewish women are reported. A detailed description of the group composition is provided. Although all the women were from similar socioeconomic and cultural backgrounds, there were sufficient individual differences in life experiences and personality to facilitate good interaction. All of the women had children and stable marriages and had been receiving individual psychotherapy. The group was presented to them as an additional procedure that would focus on emotional maladjustment with no emphasis on dieting or weight reduction. Kaplan notes her difficulties in dealing with this group of women, as reflected in her description of their manner and the content of the group sessions. The group members are portrayed as very competitive, boisterous, uninhibited, and insensitive to each other's feelings. The women competed for attention by raising their voices, and the therapist had to interfere often to maintain order. Initially, Kaplan reports, the women rationalized their volatile behavior. Later, as they came to realize that the inability to wait their turn reflected a need for immediate gratification and an inability to deal with frustration, they began to control themselves. The content of the group sessions is described. Focus was on the issues of food, feelings about obesity, sex, relationships with parents, husbands and children, conflicts about femininity, and, finally, weight loss and dieting. The author points out how the individual therapy aided the group process and how progress was made. She reports that four of the five women lost weight with the support of the group, and the fifth had not gained any weight. All of the women have obtained some insight into the causes of their overeating and an awareness that they must assume responsibility for becoming thinner. Although obesity remains a problem, all have made improvements as a result of therapy. They are better able to tolerate conflict, anxiety, and frustration, and they are more sensitive to the feelings of others. Their relationships with their families have improved. Kaplan relates that exhibitionistic tendencies, denial of sexuality, and lack of self-discipline were the problems this group illustrated most vividly. The fact that orality has a different purpose for each woman is indicative of the symptom's complexity. The author concludes by indicating plans to continue this group indefinitely in the hope that it will illuminate the effect of group relationships on the treatment of obesity.

286.

Kraft, T. Treatment of the housebound housewife syndrome. *Psychotherapy and Psychosomatics*, 15(6):446-453, 1967.

A report is presented of a study designed to investigate the possibility of completely curing a housebound, or agoraphobic, housewife. Concentration was initially on the treatment of her frigidity, a trait Kraft found common to agoraphobics. He then dealt with her inability to leave the house. The final step was resolving her dependence on the therapist. The case of a 30-year-old mother of two who served as the basis for this study is described in detail. This woman had been housebound in various degrees for 6 years and found sex with her husband "revolting," although she pretended to enjoy it. She had several lovers with whom sex was better, but she had never achieved orgasm. Her phobic symptoms appeared when her last lover was beginning to lose interest in her. Treatment was based on Wolpe's method of systematic desensitization, using injections of a barbiturate, methoxitone sodium, to induce relaxation. The first course of treatment consisted of 31 sessions in which a stimulus hierarchy designed to combat the patient's anxiety about sexual contact with her husband was worked through. Kraft reports that after the 23rd session the patient was able to enjoy sexual intercourse with her husband and reached climax level for the first time. The second phase of treatment focused on her housebound difficulties. Eighteen desensitization sessions were devoted to dealing with her anxiety about leaving the house. At the end of these sessions, she felt at ease going outside but was highly dependent on the therapist. The next 24 sessions were devoted to breaking this dependence using the process of "thought stopping" (Wolpe). This treatment ended when the patient reported visualizing intercourse with the therapist, and the needle containing the barbiturate was immediately withdrawn, acting as a severe aversive stimulus. Kraft suggests that this was a turning point in the treatment — the patient began to make "a more adequate adjustment to her husband." A report the patient wrote for the therapist in which she noted all the things she was able to do as a result of therapy is reproduced. "I am more placid, not aggressive any more. . .more realistic in my attitude toward life." At a 9-month followup, the patient was recovered from her housebound syndrome (agoraphobia) and could "tolerate intercourse with her husband." Noting the success of this treatment, while successful treatment of agoraphobia is so rare, Kraft suggests that the initial treatment for frigidity may have been a contributing factor in the recovery. He also hypothesizes that the degree of improvement in this case may be related to the strength of the patient's transference to the therapist.

287.

Krause, Charlotte. The femininity complex and women therapists. *Journal of Marriage and the Family*, **33(3):476-482, 1971.**

This article focuses on the "femininity complex," a complex that limits women's choices. The following configuration is defined as comprising the "femininity complex": (1) the binding of a woman's life to a man, (2) the denial of her own needs to serve those of her husband and children, (3) a sense of abnormality if she does not marry and bear children, and (4) an internal prohibition against self-assertion and any development outside the context of the family. Believing that this complex is part of many women's functioning, Krause suggests that counselors must learn to help women work through it to creative solutions. She notes that women often seek therapy because of their concerns about getting or keeping a man, since the heterosexual relationship constitutes the only honorable identity for any but the most extraordinary women in this society. Chesler's view of psychotherapy as merely another dependency structure for women is considered distorted, for Krause believes therapy can help women realize their oppression and dependency and gain the strength to change their ways of relating to others. Krause points out that many women fail to commit themselves to their work the way men do, because work outside the home is regarded as secondary to their truly feminine and natural role as wife and mother. Women often seek therapy because they cannot fulfill their internalized patriarchal ideal of womanhood. The "femininity complex" keeps women from exploring all possible solutions by presenting a predetermined "right way." An example is given, from the author's practice, of a woman who was able to work through her "femininity complex" and her internalized sexism and come to realize she could lead a satisfactory life as a single woman. Although this woman had many strengths, therapy was necessary to free her from a pathological state of mind that made the experience of life as a single woman fraught with anxiety and depression. Noting that the "femininity complex" is often reflected in the selection of a male therapist, Krause points out the advantages of a woman therapist for some women — sexual concerns may be discussed with greater ease, and a source of potential identification with an understanding, capable woman who is successfully employed outside her home is provided.

288.

Liebman, Ronald; Minuchin, Salvador; Baker, Lester; and Rosman, Bernice L. The treatment of anorexia nervosa. In: Masserman, Jules H., ed. *Current Psychiatric Therapies*. New York: Grune & Stratton, Inc., 1975. pp. 51-57.

The author discusses the treatment of anorexia nervosa, a disease which occurs more frequently in women, with a combination of operant conditional and structural family therapy. The patients were 10 girls from white middle-class families whose ages ranged from 9 to 18 at the onset of symptoms. The treatment program, which consisted of a series of steps with specific goals, is described. The first part of the program, the inpatient phase, included five girls. The other five began the treatment in the second part, or outpatient phase. After the girls underwent complete medical evaluations to rule out organic causes for the anorexia, a hospital regime was initiated. The family psychiatrist held informal lunch sessions with each patient to assess the degree of her negativism and anorexia, to establish a way of relating to her on the issues of sharing and eating food, and to informally gather information about her relationships. As part of an operant reinforcement paradigm, in which physical activity was completely dependent on weight, the patient was not allowed to leave her bed for any reason unless she gained at least ½ pound each day. At the end of the first week of hospitalization a luncheon was held with the patient, the pediatrician, the family psychiatrist, and her entire family. The goals of this luncheon were (1) to enable the patient to eat with her family without a power struggle and (2) to dismantle the family's myth that everything is fine with them except for the sick child, so that they will be able to recognize their interpersonal conflicts. Each patient was able to eat her entire meal at this family gathering, and all of the patients were discharged within the 2 weeks following. A second family lunch session was held on the day of discharge to explain the details and goals of the outpatient program. The details of this program, which consisted of a new reinforcement paradigm for eating to be enforced by the family, are described. As weight gain continued after an initial testing period, the focus of therapy shifted from eating and the behavior paradigm to interpersonal issues. Eventually concentration was on the problems between the parents, who began to see the family therapist on their own. The goals of this therapy are defined as disengaging the children from parental conflicts and then resolving these conflicts. The authors report that this treatment proved successful for nine subjects; they were able to maintain normal weight without relapses after the program ended. Inpatient treatment lasted an average of 14.5 days and family therapy continued for an average of 7.2 months. The authors conclude that when used in the context of structural family therapy, behavior modification paradigms are effective methods for initiating weight gain. Family therapy is essential, however, for other therapy will be undermined unless there are positive changes in the family system.

289.

Maas, Jeannette. The use of actional procedures in group psychotherapy with sociopathic women. *International Journal of Group Psychotherapy*, 16(2):190-197, 1966.

This article focuses on an experiment conducted with 46 inmates at the California Institute for Women. These inmates were identified as unsocialized individuals because they were all below the cutting score of 28 on Gough's socialization continuum (Gough, 1961). Maas discusses at some length the experiment's theoretical premise. It was hypothesized that antisocial persons who experienced relationships with others in psychodramatic procedures would develop a greater sense of interpersonal consistency as measured by Block's (1961) Ego Identity Scale. The 46 inmates were matched with a control group of psychiatric technician trainees who tested as nonsociopathic. The two groups were significantly different ($p < .01$) on the Ego Identity Index, with the controls exhibiting a much greater degree of interpersonal consistency. After this testing, the inmates were divided into two groups. One group participated in 26 group therapy sessions, including psychodramatic procedures, and the control group received no treatment. The psychodramatic techniques used in the group sessions are itemized. The course of the group therapy, half of which was devoted to actional procedures and the remainder to more traditional group therapy methods, is described. Maas notes that the women were initially averse to experiencing the anxiety and emotional involvement inherent in the role of psychodrama protagonist. As they became more involved, however, they were willing to experiment more with personal problems. The sessions then entered a second phase in which the participants expressed hostility toward the therapy and everything else. During this stage, conflict with authority figures was the major theme. Toward the end of this period, conflicting introjects began to emerge in the psychodrama, and the group moved into its third and final phase. During this period, their real feelings about themselves and their fears emerged. Maas reports that this phase proved particularly valuable, for the women were able to recognize and explore many of the distortions in their perceptions of others and their motivations. When the Ego Identity Scale was readministered at the end of therapy, there was a significant difference between the groups beyond the .05 level, with the psychodrama group showing a stronger sense of personal identity than the control group. Maas also reports on subjectively observed advantages to this therapy approach. Suggesting that further experimenting needs to be done, she concludes that the use of actional procedures combined with group therapy is a promising approach to the treatment of sociopathic disorders.

290.

Modlin, Herbert C. Psychodynamics and management of paranoid states in women. ***Archives of General Psychiatry*****, 8(3):263-268, 1963.**

Modlin reports on his study of projective-delusional-paranoid illness. The criteria for selecting only "pure" cases of projective-delusional psychic mechanism are described. The study's five women subjects (aged 30-45) are characterized as having marked similarities. All had been married for several years with adequate sexual adjustment, and all had exhibited considerable stability and ego strength at the same time they presented a psychotic picture. Their premorbid adjustment, with its remarkable psychosocial stability, is discussed. The onset of illness in each case was precipitated by an alteration in the husband-wife relationship associated with decreased frequency of sexual intercourse. The development of the illness is examined for all of the women. In each case a florid delusional system evolved from suspicious attitudes and ideas of reference.

The duration of the illness and previous psychiatric care are described for each of the women. The general treatment principles and their rationale are presented. The hospital doctor maintained firm control and management of the patient. Delusional productions were accepted with minimal comment, although any doubts the patient expressed were encouraged. Activities that fostered constructive behavior and development of the patient's talents, interests, and latent assets were strongly emphasized. The husband and other significant relatives were involved in social casework, and the husbands were encouraged to assume a more dominant role. As a result of treatment, all of the women improved. Their delusions disappeared, and they were discharged from the hospital. In followup interviews 3 to 5 years later, four of the women were functioning well with no apparent residuals of their illness. Based on his observations and conclusions, Modlin presents a chain of events that culminated in the paranoid illness of these five women. With a disruption of the husband-wife relationship, these women were not secure enough in their feminine role and self-concept, and their psychosexual identity and psychosocial status lost certainty. A depression resulted, and self-accusation and censure were exhibited. Regression then occurred with a projective-delusional mechanism appearing. In the five cases studied, delusional content showed the women to be desperately clinging to their heterosexual identity. Modlin validates his analysis of the causes of the illness by noting that the disappearance of delusions coincided with the patient's removal from a stressful situation, with her being helped to reassert her feminine social role and regain her self-esteem, and with the reestablishment of the husband-wife relationship. Modlin indicates that careful examination of these cases provides no evidence of homosexual preoccupation.

291.

Powers, Henry P. Psychotherapy for hysterical individuals. *Social Casework*, 53(7):435-440, 1972.

Powers describes the methods he developed for treating women diagnosed as hysterical personalities. The material is derived from detailed notes on the progress of psychotherapy with 13 female hysterical personalities. The results of this therapy ranged from minimal behavior change to successful personality change toward emotional maturity. The therapeutic techniques were drawn from psychoanalysis, transactional analysis, ego psychology, crisis intervention, social casework, and systems theory. Powers reports that this psychotherapeutic method is dependent upon establishing an accepting, nonjudgmental, reality-based relationship and the development of the patient's ego to mediate and provide rational controls between her id impulses and feelings and the superego guilt that follows. A summary of the etiology and dynamics of the hysterical personality is provided, along with a discussion of the course of the psychotherapy. Powers identifies the first task as establishment of a therapeutic contract in which all goals and expectations about the process of therapy are made clear. A short period of crisis intervention then ensues, followed by the therapist taking a specific case history to be used in the therapy. During this process, the patient can be helped to understand that there is nothing sinful or unacceptable about feelings or desires, but their expression must be controlled. Powers indicates that the patient must be held responsible for her behavior at all times. Early in therapy an expectation of equality with others is established that counteracts the patient's transference. This increases self-esteem and places the burden of change on the patient. When the patient begins to test the therapist to see if he will reject her, Powers suggests that the therapist identify the behavior as such and discuss the patient's fear that causes it. Early discussion of sex is presented as vital to the therapeutic process, and the use of sodium amytal as a therapeutic aid is noted. Powers recommends that therapeutic attention be focused on anger, because it is the human emotion that exemplifies other difficult to express emotions, and because anger is a major problem for hysterics. A frequent review of the progress of therapy is presented as a valuable therapeutic technique. It helps the hysteric to evaluate her self-image objectively as well as making the course of therapy clear. The necessity of helping the patient unlearn her negative self-concept, and techniques for doing this are discussed. The process of termination, when the patient has reached an appropriate balance between dependence and independence, is an important part of the therapy process. The author concludes that the patient need not be "cured" to terminate therapy; it is only necessary that she has learned the lessons of therapy and has profited from them in terms of emotional maturity and self-esteem.

292.

Scheidlinger, Saul, and Holden, Marjorie A. Group therapy of women with severe character disorders: The middle and final phases. ***International Journal of Group Psychotherapy*****, 16(2):174-189, 1966.**

This ariticle focuses on the middle and final phases (sessions 51 through 205) in the group treatment of five socially disadvantaged Negro women (see Scheidlinger and Pyrke, 1961, for a report of the first 50 sessions). Three of the original group of eight members had dropped out for reality reasons. All the women were diagnosed as having character disorders with early fixation levels. All had experienced marked emotional and cultural deprivation and exhibited the ego pathology typical of people who have suffered early traumatizations. The authors summarize the ego-strengthening nature of the initial phase of the group treatment with its climate of emotional support and nurturing. They note that by the end of this phase the women had become active participants in the group. The middle phase of the treatment is characterized as "ego repair." During this phase, feelings began to be looked at and examined rather than simply released and tolerated. The anxiety created by facing feelings was tolerable because of the members' greater personal strength and trust in the therapist as well as their strong attachment to the group. The issue of values began to emerge, and there were gradual changes in attitudes and the incorporation of new values. The group members began to assess their real-life circumstances and, instead of running from the anxiety and depression this created, they tried to master and understand their reactions. The authors report that the therapist used every opportunity during this middle phase to help each woman evolve a coherent self-image. By the end of this treatment phase, unmistakable signs of healthier attitudes and improved ego functioning were exhibited by all the women. The final phase of treatment is termed "integration." The women began to try to assimilate and synthesize their past experience with the present and to integrate their experiences within the group with those on the outside. The women's review of their group experience and how each had been helped by it is presented. The authors note that during this final period heterosexual and Oedipal themes emerged more frequently. The group members' regressive reaction to the idea of termination is presented. The women are reported to have been able to manage quite well on their own in the year following the group's termination. Developmental sketches of two of the group members are provided. The advantages of group therapy as compared to individual therapy are presented. The authors contend that this kind of group has particular applicability for community mental health and public welfare programs.

293.

Scheidlinger, Saul, and Pyrke, Marjorie. Group therapy of women with severe dependency problems. ***American Journal of Orthopsychiatry*, 31(4):776-785, 1961.**

The authors provide a preliminary report of 50 weekly group therapy sessions held with an experimental group of eight Negro women whose diagnosis had been character disorder with early fixation levels. Especially marked dependency problems are noted, and it is indicated that all of the group members suffered from early deprivations and the ego pathology that accompanies childhood traumatizations. To accomplish the immediate treatment task of ego strengthening, the authors found it necessary to create an atmosphere in which the clients could shed their defenses and come to express and perceive their intense feelings. In contrast to the approach used in group therapy with less disturbed individuals, the therapist took a very active role from the start. Her active participation was interpreted as showing she cared, which was very important for the group members. The authors comment upon the relative ease with which these women were able to express their feelings, and the support and comfort they offered each other from the beginning of therapy. A great deal of anger was expressed in the earliest sessions, with the women identifying others, primarily husbands and children, as the source of their troubles. Later, there was a shift from anger to compassion and toward some pleasure in responsibility. In recognizing their children's feelings, the women began to have flashes of self-understanding and to acknowledge personal feelings. By the 50th session all of the women freely expressed their feelings, and awareness of the relationship between their childhoods and their current problems appeared close to the surface. Sketches of two of the participants, which emphasize their group experience, are provided. Reiner and Kaufman (1959) are cited concerning the dynamics in individual therapy of adult character disorders, and the similarities observed in this group process are noted. The authors suggest that there is something inherent in a supportive group approach that is particularly suitable for clients such as these women. They postulate nine elements of the group process that make it so effective. The group is considered to be especially important in providing ego support and strengthening, and in lessening fears of interpersonal closeness.

294.

Symonds, Alexandra. Phobias after marriage: Women's declaration of dependence. *American Journal of Psychoanalysis*, 31(1):144-152, 1971.

Symonds describes her interest in, and treatment of, young women who, though previously independent, self-sufficient, and capable, show marked deterioration following marriage. Commonly, such women develop phobias or other signs of constriction of self, resulting in excessive dependency and helplessness. Symonds focuses on three patients, presenting their case histories in some detail and identifying common features. Characteristically, the women accept all blame in their marital relationships. They do not criticize their husbands but, instead, build up explosive rage that is unknown to them both. The effort to avoid all open friction results in tremendous personal restriction in their lives. Symonds considers the similar backgrounds of these women important to an understanding of later problems. They all came from families where self-reliance, independence, and control of feelings were necessary and where there was little respect for the interests of children. From early childhood, they developed skills and qualities which gave the illusion of strength. They repressed both their healthy needs to be taken care of and the child within them. Marriage represented an opportunity for them to be dependent without self-criticism and self-hate, a "declaration of dependence" (Carl Binger), and a confirmation of their feminine identity. In treating these women, Symonds focuses on the woman, not on the marriage or the husband. Treatment is a painstakingly slow and prolonged process, with often only partial success. The women tenaciously refuse to accept the concept of separateness. They do not have much difficulty recognizing their anger, however, and this recognition relieves much of their depression. Yet, except for being less depressed, they may not experience much change in their lives for a long time. Symonds suggests that the prolonged analysis of these patients may have been necessary, for by way of the analytic relationship they could permit themselves to be taken care of by the analyst. Discussing the significance of phobias in these women, the author describes their fears as symbolic expressions of how they close themselves in, repress their impulses, and imprison themselves. She also identifies another fear, their fear of being *in* control, adding that the women are usually unable to understand direct interpretation of their fears early in therapy. Their problem has nothing to do with femininity or masculinity; it is the more basic fear of people who are unable to actualize their own growth and development, asserts Symonds. Additionally, she points out that many women suffer this difficulty because of cultural prejudices which have blocked their full participation and growth and encouraged them to defer their own development and live vicariously in others. Symonds concludes that with prolonged treatment women with phobias after marriage gradually acquire enough sense of self to make their needs known to themselves and their husbands and to support and not abandon themselves.

295.

Szyrynski, Victor. Anorexia nervosa and psychotherapy. *American Journal of Psychotherapy*, 27(4):492-505, 1973.

Szyrynski outlines contemporary views of anorexia nervosa with particular emphasis on the importance of dynamic psychotherapy in its treatment. A brief historical review is given and the condition is reported to be essentially psychodynamic in origin. Anorexia nervosa is defined as a "psychogenic food refusal syndrome" and Cobb's (1950) triad for diagnosing it — voluntary resistance to eating, conspicuous loss of weight, and the presence of amenorrhea — is presented. A detailed description of the behavioral and physical characteristics of anorexia nervosa is included. Szyrynski reports that this condition occurs most frequently in adolescent girls and suggests that it may be related to their efforts to find their sexual identity. Anorexia nervosa generally occurs in families where the mother dominates and the father is a passive, ineffectual figure. Szyrynski stresses the importance of a psychodynamic understanding of the condition for the planning and application of psychotherapeutic treatment. Although patients differ considerably, most of their psychodynamic situations are related to sex and hostility, two problem areas which are discussed in some detail. A section is devoted to differentiating anorexia nervosa from other organic and psychiatric conditions when making a diagnosis. The author fully describes his treatment approach, which consists of physical support for the patient's failing physiological functioning and psychodynamic support toward reorganizing the patient's personality. Psychotherapy is identified as of paramount importance in treating these patients who manifest low ego strength, show a seriously disturbed perception of reality in the area of food and eating, and suffer from conflicts involving sex and hostility. Ventilation, which alleviates guilt and improves ego strength, is seen as vital to therapy. Introjection of the therapist's "well-integrated" personality is also an important source of ego support. Szyrynski suggests that the topics of food and eating not be confronted until ventilation and introjection of the therapist's attitude desensitize the patient in the conflict areas of sex and hostility. Then, food and eating can be handled in an objective and relaxed manner, and the patient can become comfortable in dealing with them. The final aspect of treatment discussed is managing the patient's environment. Szyrynski suggests that this may prove more difficult than handling the patient herself and indicates that removing patients from their homes may be indispensable in some cases. In conclusion, the author briefly reviews results in 16 cases of anorexia nervosa he studied closely and notes that psychotherapy appears vital to recovery.

296.

Wollersheim, Janet P. Effectiveness of group therapy based upon learning principles in the treatment of overweight women. *Journal of Abnormal Psychology*, 76(3):462-474, 1970.

In a report on group therapy based upon learning principles, Wollersheim identifies weight loss as an objective outcome criterion that is particularly suitable in assessments of therapeutic effectiveness. She randomly assigned 79 overweight women students (median age = 19) to one of four treatment conditions: (1) social pressure — designed to foster and use social pressure in reducing (described as highly similar to the nationwide TOPS weight reducing groups); (2) nonspecific therapy, a control for the effects of group treatment, emphasizing discussion of underlying causes and relaxation techniques; (3) focal therapy, the modality of interest, using instrumental learning techniques; and (4) no-treatment control, in which subjects were asked to wait until completion of the experiment for their program. Therapists were two male and two female clinical psychology Ph.D. candidates, each of whom treated one group of five subjects in each treatment category; this procedure held constant potentially biasing factors such as therapist's personality and sex. The subjects in each of the three treatment conditions met for 10 sessions over a 12-week period. All subjects received the same information on weight reduction and were urged to decrease calories and lose 2 pounds per week; they then received the treatment appropriate to their group assignment.

All three treatment groups had significant weight reduction compared with controls. Both posttreatment and at the 8-week follow-up, the focal group had lost significantly more weight than the other treatment groups. Half of the focal subjects lost 9 pounds or more during the 12-weeks protocol, whereas, for the other treatment groups, 33 percent and 21 percent lost 9 pounds or more. None of the treated subjects had a significant weight gain, but 11 percent of the controls did. Focal group subjects had a significantly greater reduction in designated undesirable eating behavior than other groups. There was no evidence of symptom substitution. Factors such as extraversion-introversion, anxiety, and physical activity did not predict outcome. According to Wollersheim, the results demonstrate that treatment based on behavioral principles is superior to nonspecific treatment or treatment based on social pressure. The results also indicate that lengthy nonspecific therapy sessions may not be more effective than such organizations as TOPS.

297.

Woolson, Allen M., and Swanson, Mary G. The second time around: Psychotherapy with the "hysterical woman." ***Psychotherapy: Theory, Research and Practice,*** **9(2):168-175, 1972.**

The authors discuss their method of treating patients with symptoms that classify them as "hysterical women." The methodology was drawn from learning theory and social psychology. Some of the characteristics, as well as the therapeutic goals, of four women who were treated in individual therapy are presented in tabular form. After the patients identified their goals, the decision was made to focus therapy on achieving better male-female relationships. The traditional therapist-patient model was replaced by an "architect-client" model designed to maximize the patients' resourcefulness, competence, growth, and future. Together the patient and therapist defined the patient's goals and explored why the patient was not the kind of person she wanted to be. The authors describe how they dealt with information about factors in a patient's childhood that she perceived as handicapping her and factors in her present life that she felt contributed to her unhappiness or "sickness." The next goal was to convince these women to substitute new behaviors for some of their more dysfunctional methods of trying to attract and keep affection and attention, for a trial period of several weeks. Inductive techniques and objective statistical material about the effects of reward and punishment were presented to the women. The objectives of persuading each woman to try out new behaviors are as follows: (1) to get her to adopt more acceptable methods of interacting at least on a trial basis, (2) to teach her the process of observing people in her milieu more empathically, (3) to teach her to adjust her behavior to the demands of her situation, and (4) to keep her aware that she is testing in real life what she has learned in theory about reward and reinforcement. A chart is provided of some of the behaviors identified as needing immediate substitutions and the substitutions. The authors report that all the patients quickly concluded that their new behavior was working well and were enthusiastic about continuing with it. At this point, when progress had been made in their behavior, focus moved to the three interlocking problems identified as needing to be resolved for women with this syndrome — frigidity, fear of loss of love that can create fear of loving, and ambivalence about accepting male domination. To deal with fear of loving, the therapist built a theoretical model of love to replace the woman's idea that love was a magical, unpredictable phenomenon. She was taught that relationships can be maintained if one behaves empathically. Frigidity was overcome by talking through childhood experiences and thoughts about sexuality. All the women were encouraged to talk about their feelings regarding acceptance of male domination and to use selective, subtle, and frequent reward for behavior they liked instead of their old passive-aggressive patterns of dealing with their ambivalence about male domination. The authors report that all four women made substantial gains in approaching their stated goals in the first 4 months of treatment they suggest that the women's behavior may have improved because they had been taught to perceive changing their behavior as the best way to achieve their goals. The primary achievements for each of the women seemed to be in the use of more acceptable behavior, more capacity for affection, less frigidity, and decidedly more self-assurance in interpersonal relationships.

Special Populations

Lesbian Women

298.

Escamilla-Mondanaro, Josette. Lesbians and therapy. In: Rawlings, Edna I., and Carter, Dianne K., eds. *Psychotherapy for Women: Treatment Toward Equality*. Springfield, Ill.: Charles C Thomas, Publisher, 1977. pp. 256-265.

The author begins her discussion of lesbians and therapy by noting the dearth of information about lesbians and the abundance of ugly myths and cruel folklore. In a section entitled "Liberalism Is Not the Answer," she maintains that lesbians can find little comfort in the current liberal approach to homosexuality. Focusing first on the current liberal church and legal view, she then criticizes the two approaches of mental hygienists: (1) at least make them comfortable in their sick behavior if they cannot be cured, and (2) "I don't care what you do in bed, that's your business." A *vote* by any group of psychiatrists, social workers, and psychologists that homosexuality is not necessarily pathological behavior is regarded as no great cause for joy. Instead, the author considers it an appalling absurdity that one has to lobby one's local psychiatrists for a vote of sanity. Escamilla-Mondanaro believes that any therapist who is reared and trained in this society and who is not a lesbian herself is not equipped to provide therapy to lesbian clients. She contends that a heterosexual therapist who wants to work with lesbians must first admit ignorance and replace defensiveness with a willingness to explore the entire issue of sexuality. The present level of ignorance about sexuality is then examined, and androgyny and sexism are identified as basic issues. Once the therapist has prepared herself with a basic understanding of feminism, sexism, and sex-role stereotyping, and has explored her own sexuality, the next step is to test her fantasies regarding lesbianism against reality. The research of Hedblom (1972) is cited to dispel fantasies and provide a view of lesbians as they really are. Additionally, the author suggests the need for a therapist to

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acquaint herself with the attitudes and oppression of special groups. She discusses the problems of the adolescent lesbian, the lesbian mother, and lesbian couples and families and makes recommendations to therapists. She suggests helping the teenager to validate her individual experience, creating a safe place for her to discuss her feelings, accepting the teenager's attitudes, referring her to a teen rap group for lesbians, and acquainting her with some of the newer books written by and for lesbians. The author recommends that therapists who want to work with lesbian mothers, begin by using whatever power they have to stop the courts from making custody decisions based solely on a woman's sexual preference. Since lesbian couples tend to favor stable long-term relationships, she recommends that couple therapy be made available and notes that the lesbian commitment must be regarded as equal to a heterosexual marriage-type relationship. In concluding, the author writes that the only way mental health centers and schools can demonstrate their good faith to the lesbian community is to hire lesbian therapists and faculty. She asserts that "lesbian therapists must come out."

299.

Homosexual Community Counseling Center. Proceedings of a conference, May 4, 1974. Gay couple counseling. *Homosexual Counseling Journal*, 1(3):88-139, 1974.

The proceedings are presented of an all-day conference on gay couple counseling held by the Homosexual Community Counseling Center for members of the helping professions. The proceedings include an introductory address, edited transcripts of a therapists' panel on female couples, a therapists' panel on male couples, a panel of female couples, a panel of male couples, and summaries of the small group discussions. In the introductory address, Ralph Blair discusses the concept of a continuing relationship and the common notion that homosexuals cannot maintain long-term relationships, pointing out that an increasing number of homosexual men and women are trying to develop fulfilling relationships. Blair identifies the need for mental health workers to contribute to the development of appropriate theory and technique for meeting gay relationship counseling needs and expresses the hope that the conference discussion will aid in this task. Included among the problems and issues discussed by the therapists' panel (a moderator and five panelists) on female couples are the following: the similarities and differences in the problems of heterosexual and homosexual couples and in the counseling approaches used with these couples; whether gay couples come to counseling for permission to terminate the relationship; whether individual feelings about being homosexual affect the nature of the couple relationship; whether homosexual couples pattern themselves after straight couples and whether this may present problems, such as role stereotypes; and how to counsel a couple who disagree on the value of monogamy in their relationship and whether this type of problem has increased among lesbian couples due to the ideologies of the women's movement. The panel of female couples (a moderator and three couples) introduced themselves and explained that their focus would be on providing specifics about how they dealt with their problems. The problems and issues they discuss are as follows: their first lengthy relationship and orientation of their families to their lifestyle; monogamy; therapy with a straight female therapist; establishment of a role pattern, or use of the straight role model and subsequent problems; sexual experiences with men and their affect on the lesbian relationship; and rearing children as a gay couple.

300.

Mundy, Jean. Feminist therapy with lesbians and other women. *Homosexual Counseling Journal*, 1(4):154-159, 1974.

In an article on feminist therapy with lesbians and other women, Mundy draws a parallel between what is now happening in the women's movement and her present therapy efforts. She identifies the first step toward the goal of the women's movement and of a therapeutic session as helping the woman patient to get in touch with her feelings. As a feminist therapist, Mundy believes that a woman needs to be self-defined rather than defined by the person she is relating to sexually, and she suggests that women need help in developing full and equal relationships in which they never abandon themselves. Any woman reared in this puritanical society will have problems with identifying her anger and sexual attractions, but the lesbian woman has even more difficulties. The lesbian often represses her feelings of sexual desire for another woman, because past experiences have taught her that other women generally will neither understand nor accept her advances. The therapist's most difficult task with a lesbian, as with a heterosexual woman, is getting her to forget the pain of a past severed relationship and helping her find the courage to try again. All women share the problem of what to tell their mothers concerning their sexual lives, even women who have worked through every other anxiety about their sexual relationships. Additionally, lesbian women often are so glad to be tolerated that they accept even more abuse than other women. Mundy stresses that feminist therapy is essential with all women but especially so with lesbian women. She supports her feelings with a verbatim statement made by a lesbian patient whose first two psychoanalysts worked to convince her to be "straight." In contrast to the philosophy and practice of traditional psychotherapy, the relationship established between therapist and patient in feminist therapy is equal and very real. Mundy discusses the process and goals of her therapy sessions, relating that she is an active participant who listens to her patients and who intervenes with feeling to confirm or disagree with their perceptions. She points out patterns, explains processes, and teaches the psychology of behavior. Dreams are interpreted, but, unlike in traditional psychotherapy, they are dealt with as here-and-now experiences and the dreamer is held responsible for all that occurs in her dreams. In this feminist therapy process, the aim is to help the woman to be herself, to feel her feelings and express them directly, to be consciously aware of her actions, to live in the present, and to learn to provide her own structure and to judge herself rather than allow others to judge her. A small piece of a case is presented to illustrate how philosophy affects treatment. Telling of a 40-year-old female patient who wanted to leave her husband of 15 years and two preteen children to go with her new female lover, the author quotes the views of several psychiatrists and suggests, on the basis of their comments, how they might counsel this patient. She then presents her process with the patient, who was encouraged to examine her feelings and to make a conscious choice.

301.

Pendergrass, Virginia E. Marriage counseling with lesbian couples. *Psychotherapy: Theory, Research and Practice,* 12(1):93-96, 1975.

Marriage counseling for lesbian couples — based on current therapeutic perceptions of homosexuals as ordinary humans with minority sexual orientations — is the subject of this report. At first, Pendergrass saw one partner who had been referred to her, but she subsequently initiated joint counseling when difficulties with the other partner appeared to be basic to the problem. The approach used in this joint "marriage" counseling was along the lines used by family therapists with emphasis on effective communication techniques. Two case histories are presented, and it is pointed out that in both cases the problems were unproductive patterns of relating, a problem area of heterosexual couples as well. Both couples revealed strong traditional sex-role stereotyping with one partner taking the dominant/aggressive and the other the submissive/passive role. Pendergrass notes that lesbian couples are less flexible in their sex roles than male homosexuals and suggests that this acceptance of sex-role stereotyping is a sign of poor personal development that would also cause problems in heterosexual marriages. She proposes five hypotheses concerning lesbian couples that she considers potentially useful for experimental investigation. Based on her observations and the hypotheses derived from them, Pendergrass suggests that sex roles would be a fruitful area for discussion and experimentation with lesbian couples and that increased flexibility in adherence to sex roles appears to be desirable. Additionally, traditional counseling for the improvement of communication in all areas of the "marriage" is identified as helpful. Recognizing the social pressure on homosexuals to form temporary untrusting alliances, Pendergrass recommends supportive "marriage" counseling for couples who would be happy in more stable intimate relationships.

302.

Riess, Bernard F. New viewpoints on the female homosexual. In: Franks, Violet, and Burtle, Vasanti, eds. *Women in Therapy: New Psychotherapies for a Changing Society*. New York: Brunner/Mazel, 1974. pp. 191-214.

In this discussion of female homosexuality, Riess notes that there is a lack of hard research data on this topic and that much more attention has been paid to male homosexuals. He indicates that (1) most published work on the personality assessment of female homosexuals contains methodological errors due to the use of criteria for women in projective tests that were based on signs discovered for men; (2) these same signs have a history of inconsistency even in selecting male homosexuals; and (3) the research was "contaminated" by Freud's concept of the female psyche. Several studies are cited — Armon (1960), Hopkins (1970), and Freedman (1967) — that agree on the relative lack of differences between the test responses of homosexual and heterosexual women. Citing the need for a systematic description of people labeled homosexual, Riess describes in detail two studies that provide some description of the "natural" history of female homosexuals. He presents the picture of the female homosexual that emerges from Saghir and Robins' 1973 study and focuses on three aspects of the 1968 study by Gundlach and Riess that included 226 homosexuals and 234 heterosexuals: (1) the significant similarities and differences between the two groups; (2) comparisons between homosexuals who had therapy and those who did not; and (3) comparisons between male and female homosexuals and control groups using Bieber et al. (1962) for the data on men. Riess concludes that there are no research data supporting the view that homosexuality is a pathological syndrome and suggests that the healing profession's insistence on viewing it as such is based on theoretical assumptions about the nature of men and women and their psychosexual development. The biological approach to homosexuality, which has been overwhelmingly discounted, and the psychoanalytic approach, with its assumptions based on Freud's writings, are presented. The author asserts that there is very little evidence to support the psychoanalytic approach toward the female with its emphasis on early identification with the mother and the trauma of discovering she had no penis. The case histories that are used to defend this view are all contaminated with the physician's a priori belief in Freudian theory. The question of therapy for homosexual women who seek help is examined. The author notes that once the nature of the person and its relationship to her choice of a sexual or love partner is established, therapy proceeds as in any case. The therapist is warned to avoid regarding homosexuality as a clinical entity and not to generalize from what is known about men to women. The therapist must clearly indicate that the choice of a like-sexed love partner is not necessarily pathological. Among the most difficult questions to be answered in therapy is why the woman feels homosexuality is her problem. Research shows parental expectations of and attitudes toward girl children. are a major area to be examined. Riess concludes that homosexuality, like heterosexuality, can serve to perpetuate a neurotic or psychotic lifestyle. If the neurosis is dealt with, the choice of a love partner can be made independently of partner's sex.

303.

Sang, Barbara E. Psychotherapy with lesbians: Some observations and tentative generalizations. In: Rawlings, Edna I., and Carter, Dianne K., eds. *Psychotherapy for Women: Treatment Toward Equality*. Springfield, Ill.: Charles C Thomas, Publisher, 1977. pp. 266-275.

This article is based on the author's experience of working with lesbians in therapy. A brief description is presented of the approximately 80 lesbians Sang saw over a 3-year period for either an initial intake interview or for psychotherapy. Most of the women were referred to her by the Homosexual Community Counseling Center or by private sources. Although the women came from diverse backgrounds, the population is described as biased, since most of the women worked in the mental health professions or in the arts, and all of them came directly to a counseling center or therapist known to view homosexuality positively. The only consistent characteristic in the background of these 80 women is that almost all of them assumed from childhood that they would be self-supporting. Sang reports that lesbians seek therapy for the same reasons as heterosexual women, but they bring with them experiences that can only be understood by therapists who have some familiarity with the gay subculture. Eight typical experiences and problems lesbians bring to therapy as a result of their minority status are described, and a brief case history is provided to illustrate each one. Sang notes that in many cases feelings of doubt and inadequacy disappear when the woman's individual experience is placed within a broader social context. She reports the following reasons lesbians seek therapy more frequently than heterosexual women: (1) people who are different are likely to spend time reflecting on this difference and, as a consequence, often become aware of parts of themselves they want to explore and work on; (2) there is more social pressure on lesbians than on other women, and their isolation may make them feel they can only share their problems in therapy; and (3) lesbians may look to therapy as a way of having someone in authority approve their orientation. According to the author, good therapy involves helping a person get in touch with who she is, and therapists who cut people off because of their bias against homosexuality are not helping in this process. Case histories are included to illustrate how a heterosexual bias can hinder therapy. The author notes that even therapists who voice a positive attitude toward homosexuality may express bias in their work. According to Sang, a therapist who really views lesbianism positively will be able to establish rapport and trust more easily with gay women and will be better able to understand the nuances of their lifestyle. A gay therapist can be especially effective, because her positive self-image can serve the client as a model. The fact that the therapist has gone through the same struggles can serve to validate the client's struggles. Also, it is felt that a gay therapist would be quick to confront a client when she used negative stereotypes to put herself down. Sang concludes that although a heterosexual who feels positively about lesbianism and has given thought to the minority problems of gay women may be helpful, a lesbian has most to gain in therapy by working with a therapist who shares her context closely.

304.

Walker, Betty A. Psychotherapy with gay professional women: Some personal and professional insights. ***Voices*****, 12(3):76-78, 1976.**

In this article Walker presents a brief discussion of psychotherapy with gay professional women from both a professional and a personal perspective. She relates that in this era of liberation it was the gay professional woman — essentially ignored in terms of her status, her needs, her possible conflicts, her role in the community, and her psychotherapeutic experiences — who attracted her attention. Walker associates her personal and professional awakening with a brilliant musician patient in her late twenties who was struggling with guilt and ambivalence about her gay preference. Recalling her own sense of anxiety in response to this patient, Walker recounts how she dealt with this anxiety and reexames a gay experience in her own life. The questions and conflicts raised at this time led to self-exploration of her attitudes and behavior as a therapist-woman-person. She notes that in this exploration process she became aware that homosexuality is just as good as bisexuality; that gay professional women still have fears and concerns about their gay preference even though they appear to be liberal and to have integrated their educations and professional training; that the dilemma of these women has to be faced; that her life's being different would not hinder her work with the gay professional woman; and that there was a need to deal with the issue of disclosure. Walker discusses these realizations and concludes that her own experiences, beliefs, and behaviors can help gay professional women accept themselves, advance their careers, and lead satisfying, effective lives despite obstacles that may confront and block them.

Minority Group Women

305.

Boulette, Maria Teresa Ramirez. Determining needs and appropriate counseling approaches for Mexican American women: A comparison of therapeutic listening and behavior rehearsal. (Abstract source, *Dissertation Abstracts International*, 34(B):868, 1973.) *Dissertation Abstracts International.* Ann Arbor, Mich.: University Microfilms, No. 73-19146. 168 pp.

The author compared the effectiveness of therapeutic listening (a variant of Roger's client-centered therapy) and behavioral rehearsal (role playing and social modeling) in the treatment of 36 low-income Mexican-American women who volunteered for counseling services in a community-owned and -operated service center. The most frequent presenting problems were depression, low self-esteem, decision-making problems, and disharmony with husbands or lovers. Subjects were randomly assigned to the two treatment conditions and to three bilingual college graduate counselors who had been trained in the two techniques. Target complaints were ranked at pre- and posttreatment according to the goal attainment scale, an instrument developed for this purpose. Treatment consisted of eight 45-minute weekly counseling sessions in the client's preferred language. There was no positive correlation between treatment procedures and therapeutic outcome, although the behavior rehearsal counseling method did produce significantly more favorable outcome on one of the five goal attainment scales. Client's language preference was significant at the .01 level, indicating preference for Spanish versus English language counseling. Other findings included the facts that most women were referred by agencies, had low vocational, educational, and economic attainment, rarely used available transportation and babysitting services, were from large families, and were in need of medical, welfare, and legal assistance. The author emphasizes the importance of providing services in the client's preferred language and in a central location. She recommends that innovative counseling techniques be investigated with multiple outcome measurement criteria.

306.

Jeffries, Doris. Counseling for the strengths of the black woman. *The Counseling Psychologist*, 7(2):20-22, 1976.

In recognition of both the scarcity and the negative quality of literature about black women, Jeffries focuses on the strengths of black women as a possible starting point for the development of a more inclusive counseling theory. She hopes that such a theory will stimulate new perspectives for research and practice. The strengths of the black woman are reviewed and studies demonstrating these strengths are cited to assist the counseling psychologist in developing a new and more positive orientation to black women. Initially, the strengths of both the black female child and the black female adolescent are discussed and documented so that the counseling psychologist will understand the black female's strengths at these developmental stages. Concentration then turns to the black female employee who entered the working world as a slave. Because she was forced to work outside her home, the black woman acquired an equal status with her man. The slave woman developed the capability to work and to handle demanding tasks over long periods of time and under difficult circumstances. As a result, involvement in the labor force became an economic tradition for the black woman. Reference is made to the studies of Epstein (1973) and Scanzoni (1975) which support the egalitarian theory. The black man and black woman have a relatively egalitarian relationship, with the black woman being much less bound than the white woman by stereotypic wifely roles. Since the black woman perceives herself as task capable, Jeffries suggests that the counseling psychologist focus on expanding the woman's view of herself as a worker, helping her to develop a career that will be personally satisfying. At a time when organizations are being pressured to hire blacks and women, the counseling psychologist can assist the black female client to increase her competence so that she can take advantage of the "double negative equals positive position" that exists in today's job market. The work of researchers who are beginning to investigate the positive psychological attributes of black women is cited, and findings indicating a high degree of self-confidence in black women are reported. The stages of development toward black self-esteem that were developed by several black psychologists and synthesized by Kirk (1975) — those of self-hate, self-pity, self-examination, self-knowledge, and self-esteem — are suggested as a general guide to be used when working with the black female client. The author concludes that if the self-esteem of the black woman is to be more fully understood, research models and designs which are more appropriate than the current deficit model must be used.

307.

McDonald, Thomas. Group psychotherapy with native-American women. *International Journal of Group Psychotherapy*, 25(4):410-420, 1975.

This article focuses on eight native-American women caught up in the process and problems of relocating from reservations to urban centers and the author's group therapy with them. All the women, mothers without husbands, resided at the American Indian Center in San Diego; they were relocated to learn marketable professional or paraprofessional skills. On the reservation the women had been immersed in a complex network of interpersonal relationships. In contrast, the career center, a modern facility where each family lives in a separate apartment, is a completely alien environment for the Indian women. They are sent to learn the white person's skills in the white person's language and at his/her pace. Outlets for the pressures they experience are scarce, and there is little interaction among the women who come from various tribes. When these eight women began to manifest problems, such as drinking or truancy, they were referred to the author, a consulting psychologist. The group was formed after several months of consulting with the women on an individual basis. Noting that the therapy orientation was Gestalt, McDonald describes the group's development and indicates that progress was not always smooth. As time passed, more personal experiences were discussed until even the most resistant members risked sharing their problems. The women's individual isolation gave way to group interaction and a sense of belonging developed. The group became a safe place where the pressures of daily life could be discussed. Each of the patients is described in terms of her tribal background, her individual concerns, and her manner of interacting with other group members. The conflicts created by living in two cultures are discussed as well as concerns over contact with men and drinking problems. Although McDonald indicates that it is too soon to write of the group's longitudinal effects, the subjective reports of its members show that group therapy provided a respite for them in a new and confusing world. They learned that they were not alone with their problems, could give each other support, and could confront each other when necessary. When problems became too servere, women in the group would return to their reservations and have ceremonies performed by their medicine men; this was wholeheartedly endorsed by the group and usually proved helpful. Group therapy became a place where the women could discuss their problems, explore options, and make decisions among sisters. As self-confidence increased among the women, they began to examine and discover the causes for their pain.

Women in Prisons

308.

Brummit, Houston. Observations on drug addicts in a house of detention for women. ***Corrective Psychiatry and Journal of Social Therapy*****, 9(2):62-70, 1963.**

This article presents facts and impressions drawn from the patient records and staff at the House of Detention for Women in New York City. Brummit cites figures to document the steady increase in drug addiction among women. The factors contributing to addiction are discussed, with the greatest common factor among female addicts being identified as a rejecting home environment. The author describes "the life," or underworld society, in which the addict functions and how a girl might be introduced to it. According to Brummit, intense hatred or anger is the primary emotion all inmates have in common, although most of them are unaware of their hostility. He reports on the personality and age factors of these addicted inmates by comparing them to patients in a State mental hospital. Brummit indicates that female addicts generally function well in the structured and well-defined prison environment. Based on his experience working with addicts, Brummit suggests that most treatment programs for addicts have failed because the women lack motivation and because therapeutic and rehabilitative staffs and programs have been grossly inadequate. Ignorance about addiction is another problem in treatment, and Brummit suggests that future efforts focus on combining the disciplines of the hospital, where the addict is considered a patient, and the correctional institution, where the addict is regarded as a criminal. The thrust of the therapy at the House of Detention is to drain the inmates' anger. In group discussions attempts are made to get the women to directly explore repressed feelings that center on hate. The therapy orientation is dynamic and practical, reconstructive and educational. Concentration is on helping addicts integrate and survive in the normal society from which they have been isolated. Brummit regards the present attitude of prisons as cruel and unrealistic. Former addicts are returned to the community without any followup help and often retreat to "the life," because they are ill-equipped to begin new lives. Halfway houses as an extension of prison are identified as a necessity for moving the women into the community with confidence and new goals.

Additionally, he suggests that vocational and rehabilitation programs be made available, along with psychotherapy in some sort of aftercare clinic, in order to guide adjustment after release.

309.

Daehlin, Diane, and Hynes, Jane. A mothers' discussion group in a women's prison. *Child Welfare*, 53(7):464-470, 1974.

The authors report on the discussion group they held for mothers at the Minnesota Correctional Institution for Women in 1971. A part of the prison's prerelease program, the discussion group had two goals: helping mothers to cope with their feelings of separation from their children and helping them to prepare for reunification with their families and community. Meeting weekly for 1½ hours, a group of six women soon expanded to include other interested women in the 48-inmate facility. The social worker leaders served as a liaison and as advocates for the inmates in contacts with the community (i.e., schools, day-care facilities, and foster parents). Additionally, they worked to create awareness among the prison staff of the importance of family relationships to rehabilitation. Within the group, the authors functioned as group process facilitators, providers of information, and teachers of problem-solving and communication skills. The group members, rather than the leaders, determined the content of the discussions. The following concerns, which the women prisoners chose to discuss, are reviewed: explaining incarceration to children; problems of separation for both mother and child; developmental concepts to help mothers cope with the reality of living with their children again; relationships with men; family reunification; feelings about imprisonment; their own family background and its effects; the rights of mothers in prison; and reunification with the community. Although group discussions accompanied by techniques such as role playing were the main focus of the group, the leaders were also able to involve family members in some group activities. The authors suggest that the effectiveness of the program is difficult to measure. They relate that when they attempted to start a group in 1973 for women who had already been released from prison, they were unsuccessful. Outside of prison, the women were no longer interested in a group activity. The authors report, however, that several women contacted them 3 or 4 months after release to work individually on problems they had encountered.

310.

Fodor, Iris E. The use of behavior-modification techniques with female delinquents. *Child Welfare*, 51(2):93-101, 1972.

Fodor outlines a behavior-modification approach that was used in a training school for delinquent females. The focus was on helping the girls control their own behavior—delinquency being equated with maladaptive behavior patterns. Fodor's model for analyzing maladaptive behavior viewed behavior in terms of antecedent, behavior, and consequence. Although antecedent conditions in an institution are out of the individual's control, behavior can be changed by dealing with the consequences of behavior through the manipulation of reinforcers. Punishment can be a powerful tool if one maladaptive behavior is punished while a competing adaptive response is reinforced. The major goal of this behavior modification program was to help the girls realize they could control their fate by learning to control their behavior. The training consisted of impulse control. The therapist was the source of many reinforcements, such as attention, praise, and the granting of privileges. Treatment was conducted in informal small group sessions. At first, the therapist remained neutral to make the setting positively reinforcing, but in time she began to shape adaptive behavior through her reactions to things discussed. Immediate rewards were offered for desirable verbal material; attention was withdrawn and disapproval was shown when maladaptive behavior was exhibited. The three major behavior problems in this group of girls were running away, sexual acting out, and inability to control anger. The techniques used to modify these three common maladaptive patterns are discussed. A figure illustrates the decreasing frequency of runaway behavior at the training school as the behavior modification program progressed. A modified desensitization procedure was used for runaway behavior. Sexual acting out was treated in severe cases by complete withdrawal of reinforcement (ouster from program) and punishment in the form of "honest labeling" of the behavior. To control their anger, the girls were taught to relax and anticipate consequences. They were also taught alternative responses to anger and were given some *in vivo* practice in temper control by the therapist. The author emphasizes the need to train personnel who deal with delinquents in behavior modification attitudes and techniques. Concrete suggestions are made on how reinforcement could be used to help in school and work projects that are part of release programs. In conclusion, Fodor suggests that rehabilitation programs for females based on a male model may be inadequate. Most of the girls in this program were in institutions because of family and social problems. Fodor believes that the girls should not be isolated from their difficulties but should instead be learning to cope in the community, A plan in which girls would be gradually returned to their communities is proposed. Workers would be taught behavior modification principles so that realistic halfway environments with appropriate controls could be created. Until this is done, Fodor contends that only temporary improvements can be made by using behavior modification techniques on an individual basis in existing institutions.

311.

Redfering, David L. Durability of effects of group counseling with institutionalized delinquent females. ***Journal of Abnormal Psychology*****, 82(1):85-86, 1973.**

Redfering reports on his 1-year followup of an earlier study of 18 institutionized delinquent females and 18 control subjects (Redfering, 1972). The semantic differential technique was used to determine whether the initial positive effects of group counseling on the perceptions of "father," "mother," "myself," and "peers" were still present in the experimental group. Additionally, a questionnaire was designed to obtain information about the activities and status of the sample as indices of postinstitutional adjustment during the followup period. Redfering hypothesized that the subjects who had experienced group counseling would respond more positively toward the experimental concepts than the control group and that the experimental group would demonstrate more socially desirable behaviors a year after group counseling. The subjects in residence at the girls' school at the end of the followup were interviewed and tested. Those who had been released were contacted by mail and completed and returned the semantic differential and the questionnaire. Two-tailed t tests were used, and the results revealed that the experimental group's mean scores were significantly more positive than those of the control group for the concepts of father, mother, and myself. For peers, the trend was in the hypothesized direction ($p < .10$). Data on the subjects' postinstitutional status were obtained from the questionnaires. Chi-square analyses showed that the experimental group's general status was better than the control group's as evidenced by the greater percentage of subjects released from the institution and the greater number who had not been recommitted to the institution. Indicating the need for caution in drawing unwarranted inferences and conclusions on the basis of this relatively small sample, Redfering concludes that the results indicate that some of the positive effects of counseling were still present a year later.

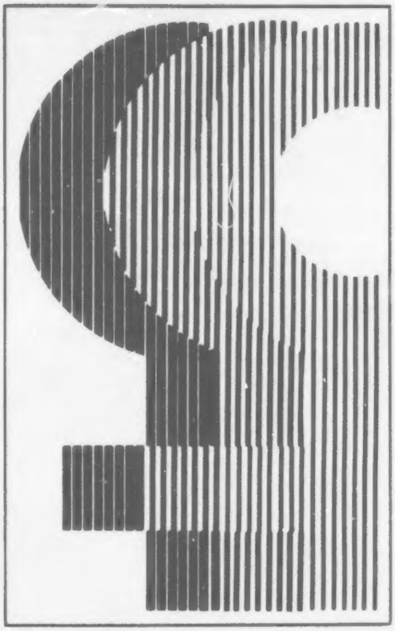
312.

Taitt, Adelaide Lenora. Counseling and recidivism: A study of women participants in the Teachers College, Columbia University Rikers Island Correctional Institution for Women Project. (Abstract source, *Dissertation Abstracts International*, 35(A):3438, 1974.) *Dissertation Abstracts International*. Ann Arbor, Mich.: University Microfilms, No. 74-26622. 118 pp.

The author reports on an in-depth case study of 10 women who participated in the Teachers College, Columbia University Rikers Island Correctional Institution for Women Project. The case study was undertaken to determine the effect of the project's counseling unit on the subjects' patterns of recidivism. The program's objective was to educate the young women during their incarceration on Rikers Island and to provide followup services upon their release at a community resource center. There were three sources of data collection for the study: the individual subject's records, interviews designed to determine if counseling had affected the rate of recidivism among the sample group, and Taitt's informal contacts with the women under study. According to Taitt, the study findings indicate that the counseling unit was an important component in the rehabilitation of this study's participants. The women most need supportive counseling that helps them meet their survival needs, that assists them in coping with their feelings of lack of self-worth, guilt, and fear, and that also provides help as they deal with the other personal problems encountered during and following their incarceration. This form of counseling is described as an essential first step in working with the women. It should precede discussion of future plans, such as education or job training. Taitt indicates that the study revealed the need for supportive counseling and also illustrated the gaps in many of the services which were available to help the female offender in her readjustment to society. She concludes that without supportive counseling services, educational programs both within and outside correctional institutions will fail.

VI.

ALTERNATIVE APPROACHES TO TRADITIONAL PSYCHOTHERAPY



Assertiveness Training
Consciousness Raising
Crisis-Oriented Intervention:
Situational Crises of Women
    Battering by Male Partner
    Breast Cancer
    Pregnancy/Abortion
    Rape
    Widowhood
Feminist Therapy/
Feminism as Therapy
Self-Help
Other
Self-Help Reading for Women

Assertiveness Training

313.

Butler, Pamela. Assertive training: Teaching women not to discriminate against themselves. ***Psychotherapy: Theory, Research and Practice,*** **13(1):56-60, 1976.**

Butler cites research showing that women have learned behavior that interferes with the full exercise of their personal power. Women often feel powerless and helpless and may allow themselves to be treated like the children they feel they are, but this submissiveness frequently results in feelings of anger, despair, and depression. Butler then identifies assertiveness training groups as an effective mode for breaking women's patterns of helplessness. In assertiveness training groups women begin by exploring their individual problems with self-assertion. From the four major areas of assertion difficulties—described as problems with expressing positive feelings, with expressing negative feelings, with setting limits, and with initiating activities—the women select specific situations in which assertion is difficult for them. These situations are ordered into a hierarchy from least to most anxiety producing so that they can be used successfully in behavioral rehearsal, the core technique of assertiveness training. After an item of the hierarchy is worked through in the group using role playing, the practice of similar assertiveness outside is encouraged. Group feedback, encouragement, and reinforcement are important aspects of the training. Butler also believes it vital to provide a female model who shows that it is possible to be both assertive and feminine. Four aspects of assertion are focused on as a means of increasing assertive behavior—verbal behavior, nonverbal behavior, autonomic responses to self-assertion, and cognitive variables. The cognitive element is very important in teaching assertion to women, because they often are afraid that rejection and disapproval will follow assertiveness. Butler notes that the assertiveness training groups for women in which she has participated have been very successful in increasing assertiveness. On the basis of the Wolpe-Lazarus assertive inventory completed by participants, she concludes that women can learn to stop denying their own competency and power and to stop discriminating against themselves.

314.

Carlson, Noel R., and Johnson, Diane A. Sexuality assertiveness training: A workshop for women. ***The Counseling Psychologist,*** **5(4):53-59, 1975.**

The authors report on a sexual assertiveness workshop designed and offered on an experimental basis at the University of Minnesota in the spring of 1975. It is pointed out that although assertiveness training has become a major mode for working toward personal growth for women, it has rarely been used for dealing with sexuality-related situations. The area of sexual behavior is described as one that elicits a wide range of feelings and provides many opportunities for either the denial or facilitation of personal rights. Noting that women often have unpleasant sexual experiences because they are reticent about expressing their feelings and desires, the authors present a list of six of the most obvious myths that form the basis of the sexual identities of American women. These myths, along with many others, work to establish a feeling of competitiveness among women and to create a feeling of powerlessness that diminishes women's sexual rights. Men are perceived as more sexual and more knowledgeable about sex than women—they know how it works and must show women the way. Nine women participated in this workshop, which met 2 hours a week for 6 weeks (one woman had dropped out after three sessions). The workshop, established on the format of women's groups, defined the need to focus positively on sexual assertiveness as a developmental process rather than negatively as an illness or problem. The objectives were as follows: to foster cooperation rather than competition among women participants; to promote the feeling that women have a right to be sexual independently of men; and to help women work through some of their conditioning and establish a new belief system that allows them to assert themselves in their sexual relationships. The authors describe what occurred at each of the six sessions and the specific exercises used to help women understand how assertiveness works and not feel guilt or embarrassment about their newly found power. The fourth session was a voluntary nude session that was offered as a means of providing the women with a sense of owning their own bodies and with the opportunity to explore their bodies and receive feedback among a group of people they trusted. Throughout the sessions both physical and role-playing exercises were done along with homework assignments of assertive behavior. Reaction sheets were completed at the end of each session. The authors conclude that 6 weeks was an insufficient period of time for achieving the workshop's goals. The women were trying out new behaviors and needed more time to integrate these into their lives. It took time for the participants to feel comfortable enough to talk among themselves about sex, let alone experiment with sexual assertiveness outside the group. A followup is planned to obtain the participants' individual evaluations of behavior changes that were facilitated by the workshop experience.

315.

Halas, Celia M. The place of assertive training in therapy with women. *Voices*, 12(3):8-12, 1976.

This article deals with the effectiveness of combining therapy with women with assertiveness training. Halas decided to try this approach after becoming aware that a pattern of nonassertiveness lay beneath most of her women clients' problems. They had been socialized to accept nonassertion as appropriate feminine behavior, and they lacked the necessary skills to act assertively. By combining therapy with a class in which assertiveness training skills are taught, Halas gave the women the tools to extend therapy gains into their daily lives, thereby shortening their therapy time. The assertiveness training proceeds in a structured manner, beginning with small things and teaching the women step by step how to gain their own human rights without violating the rights of others. The teaching of assertiveness combines insight therapy with movement toward self-actualization and reinforcement theory. The author suggests that most women in therapy suffer from low self-esteem and an adherence to the feminine sex-role stereotype. They do not trust their own perceptions and are unable to determine whether they are behaving assertively, nonassertively, or aggressively. The first task in assertiveness training is to teach this distinction. As many women have devoted their entire lives to fulfilling society's feminine stereotype, therapeutic gains can only be made by modifying the inappropriate values based on this stereotype. Halas believes that this modification of values can be dealt with most economically and efficiently in assertiveness training classes that are concurrent with therapy. Women are taught to examine how their belief systems relate to the concept that all individuals have equal rights as human beings and the right to express themselves honestly regardless of sex. They learn to be aware of and deal with the main psychological blocks to standing up for these rights, such as catastrophizing and the influence of female-role expectations. The structure of the training class reduces anxiety about the changes occurring through therapy by providing the women with a cognitive structure, by assuring them that they are not alone in their fears, and by giving them exercises, such as role playing and script writing. Women come to recognize that nonassertion lies beneath their emotional problems and/or psychosomatic illnesses. By asserting themselves, they find that they gain the respect of others, as well as pleasure from expressing both their positive and negative feelings. Halas concludes that just as assertiveness training has proven a valuable adjunct to therapy in her experience, therapy sessions might be a valuable adjunct to the many assertiveness training courses now being taught. The therapy would give women an opportunity to work through their distress. She points out some of the things women need to do in therapy while learning to be assertive—deal with their rage, blame if they feel the need, and examine their own lack of confidence in their perceptions.

316.

Jakubowski, Patricia A. Assertive behavior and clinical problems of women. In: Rawlings, Edna I., and Carter, Dianne K., eds. ***Psychotherapy for Women: Treatment Toward Equality.*** **Springfield, Ill.: Charles C Thomas, Publisher, 1977. pp. 147-167.**

This article is based on the premise that emotionally healthy people feel they can make an effective impact on their environment. To be interpersonally effective, an individual must be able to be assertive. Jakubowski examines factors that hinder women from acting assertively, discusses the relationship of nonassertive behavior to various psychological problems, and briefly defines assertion, aggression, and nonassertion. The study of Broverman et al. (1972) is cited as evidence that society views nonassertive behavior as desirable in women. Sex-role socialization teaches women to be more concerned about others than themselves, to the extent that they sometimes lose their own sense of identity. Jakubowski charts the way in which socialization is likely to inhibit assertiveness, and gives examples of how individual life experiences can further inhibit a woman's ability to assert herself. The author also writes of the manipulative techniques nonassertive women may resort to and their covert efforts to have their own needs satisfied. Aggression, or standing up for oneself in a way that violates the rights of others, is considered a byproduct of nonassertiveness. Indirect aggression, such as cattiness, is a common way of dealing with a sense of anger or disappointment that cannot be openly expressed. Direct aggression may often be the result of failing to be assertive over an extended period of time. Some women act aggressively merely because they lack assertive skills and feel that respect from others can only be achieved through aggressiveness. Assertive behavior is based on respect for oneself and others. Examples are presented to show how assertion works. In a figure the author illustrates assertiveness as a social skill that can be more effective when combined with other social skills, such as empathy, confrontation, and contracting. The text also gives examples of how assertion combines effectively with these other skills in social interaction. Jakubowski goes on to cite literature which establishes that many clinical problems may be caused by the client's inability to assert herself and to identify how assertion training can be effective treatment for these disorders. Assertion training is appropriate treatment for specific problems of depression—newly married blues, the supermom syndrome, depression due to loss, and midlife depression. Other problems dealt with include dating difficulties, jobs, child abuse, psychosomatic disorders, drug or alcohol dependence, agoraphobia and other irrational fears, and aggressiveness. Assertion training may also be effective in counseling couples to create more fulfilling lives and to reclaim their rights as human beings.

317.

Jakubowski, Patricia A. Self-assertion training procedures for women. In: Rawlings, Edna I., and Carter, Dianne K., eds. *Psychotherapy for Women: Treatment Toward Equality*. Springfield, Ill.: Charles C Thomas, Publisher, 1977. pp. 168-192.

Jakubowski's approach to assertion training extends the work of its founders and incorporates techniques from behavior therapy, rational-emotive therapy, gestalt therapy, bioenergetics, and transactional analysis. The program she describes has been created for all-female assertion training groups that met over a 10-week period with women facilitators. Jakubowski writes that a complete assertion training program should consist of four phases, or components, although some clients may require work in only one or two of the phases. A table illustrates how these four phases overlap during a 10-week program. Phase 1 includes helping clients to discriminate between assertive, aggressive, and nonassertive behavior; creating motivation for them to become assertive; and increasing their awareness of their own behavior. Specific methods for accomplishing these tasks are described; a 12-part list of items that can be incorporated into a discussion on discrimination and a table that gives the script of an assertion discrimination tape are also provided. Motivation to change can be developed through reading and discussion of behavior's consequences; awareness of behavior can be brought about through homework assignments, the keeping of assertion logs, and filling out questionnaires. Phase 2 deals with the development of a personal belief system that helps a woman identify and accept her personal rights and that supports assertive behavior. The "Basic Tenets of an Assertive Philosophy" are presented in tabular form, and Jakubowski suggests that group discussions and transactional analysis probes are most effective in phase 2. Examples are given of therapeutic procedures that can, if necessary, be employed. Phase 3 focuses on eliminating the psychological obstacles that prevent assertive behavior. The author suggests that rational-emotive procedures, relaxation training, systematic desensitization, bioenergetics, and behavior procedures might be used in different aspects of overcoming women's assertion blocks, such as their fear of being disliked or of expressing anger. A fourth table illustrates a rational-emotive homework assignment. Phase 4, the final phase, is the development of assertive skills by use of active practice methods such as behavior rehearsal or role playing and modeling procedures. The practice sessions usually follow the three basic patterns of spontaneous role play, exercise-oriented sessions, and theme-oriented sessions. Each of these patterns is described in some detail and specific exercises are given.

318.

Jakubowski-Spector, Patricia. Facilitating the growth of women through assertive training. ***The Counseling Psychologist*****, 4(1):75-86, 1973.**

The author identifies three converging trends as responsible for women's growing concern about their difficulties in being assertive—the culture's increasing recognition of the need for self-growth, difficulty with restrictive sex roles, and the growth of the women's movement and its resulting influence. Women's awareness and concern is responsible for the increasing demand for assertive skill training. The author first distinguishes between assertive, nonassertive, and aggressive behavior, defining assertive behavior as a form of personal behavior in which a person protects her own legitimate rights without violating the rights of others. She then outlines assertive training procedures and describes a semi-structured assertive training approach which has the following objectives: (1) educating the woman as to her interpersonal rights, (2) overcoming whatever blocks exist to assertive action, and (3) developing and refining assertive behaviors by means of active practice methods. Jakubowski-Spector discusses, including examples, a series of successive steps that occur in this assertive training program. When a woman seeks therapy, she will quickly realize she has a problem with assertion when examples from her personal life are used to distinguish among assertive, nonassertive, and aggressive behavior. Problems may arise, however, in nontherapy situations in which individuals do not recognize the existence of any significant problem with assertion. The author includes an example of consciousness-raising groups of married suburban women and offers suggestions for possible ways to increase their awareness and motivate them. The development of a belief system is crucial, for it will give the client support and justify assertive action. Additionally, the client needs to realize that nonassertion is harmful and to believe that she will be happier if she appropriately exercises her rights. One way for a therapist to deal with anxieties about assertion is to use the rational emotive therapy technique in which the client's irrational beliefs are attacked. Behavior rehearsal is the most commonly used technique to teach assertive skills. A special role-play experience is created in which the client has the opportunity to practice those specific assertive responses which are to become an established aspect of her behavior. Most clients generally pass through an "aggressive phase" when their responses tend to be more aggressive than assertive, but by trial and error they learn to use their feelings to prompt assertion rather than aggression. Throughout the course of training, clients typically assert themselves simply for the sake of asserting, but the hope is that by the end of training they will have acquired a more natural assertiveness. The author considers it important for people to have the skills to be assertive so that when they decide not to assert themselves it is because they choose not to rather than because they are afraid to.

319.

Linehan, Marsha M.; Goldfried, Marvin R.; and Goldfried, Anita Powers. "Assertion Therapy: Skill Training or Cognitive Restructuring." ***Behavior Therapy*****, in press.**

In this study of various approaches to assertion therapy, 79 women who responded to local advertisements for assertiveness training participated in two university programs. The study was designed to compare procedures based on a skill-deficit model with a procedure based on a response-inhibition model and to determine the influence of therapist sex on such groups. Subjects had a mean age of 34.2 and a mean education of 14.5 years; 51 percent worked full time and 16 percent part time. A within-sample matching technique based on the pretest questionnaires was used to assign subjects to one of five treatment groups — behavioral rehearsal ($N = 16$), systematic rational restructuring ($N = 16$), behavior rehearsal/rational restructuring ($N = 16$), relationship controls ($N = 16$), and waiting list controls ($N = 15$); assignment to one of four male or one of four female therapists (advanced graduate students and postdoctoral fellows) was also random. Treatment was conducted individually in eight weekly sessions. The format for the three behavioral treatment groups was similar. The therapy rationale was discussed and the treatment procedure explained during the first session. The remaining sessions consisted of practicing assertive behaviors, restructuring, or a combination of the 2 in 12 predetermined training situations. Behavior rehearsal participants were informed that their assertion problems were due to a skill deficit. Systematic rational restructuring participants were told that their assertion problems resulted from maladaptive emotional responses and beliefs in assertion situations. The behavior rehearsal/rational restructuring participants were instructed that their assertion problems resulted from both deficit skills and response inhibition due to maladaptive emotions and beliefs. The relationship control participants were told that their assertion problems were due to a lack of self-confidence, which could be overcome by the therapeutic experience of expressing opinions, beliefs, and feelings in an accepting and supportive atmosphere. Waiting list controls were notified of a delay in their treatment because of the large number of applicants. After 8 weeks they were contacted and told they would have to retake the assessment battery before the beginning of treatment. Subsequently, they were seen in a group setting and received either behavior rehearsal or a behavior rehearsal/rational restructuring training package. Measurement instruments included the Rathus Assertiveness Inventory, Assertion Difficulty Inventory, S-R Inventories of anxiousness and hostility, Social Avoidance and Distress Scale, Fear of Negative Evaluation Scales, and Rosenberg's Self-Esteem Scale. The authors report that results indicate (1) the combined behavioral rehearsal/rational restructuring therapy was superior to all other groups in increasing assertive behavior and reducing emotional discomfort associated with assertive interactions, and all three behavioral treatments were superior to both controls across most measures; (2) there were few differences among the three behavioral groups on self-report measures; and (3) on both a role-play test and a contrived situational test the three behavioral treatments were equally successful in facilitating women to make a response, whereas treatments using behavior rehearsal were more effective in improving the assertive quality of responses. Although there were no significant between-group differences, a majority of subjects reported significant changes in their relationships with men and with people in general, along with their belief that these changes were positive. At follow-up, all treatment groups maintained or improved upon gains in assertiveness but did not differ on a self-report battery. Perhaps because target behaviors and therapeutic procedures were standardized, no effect of sex of therapist was found; the authors note that this finding may not generalize to clinical settings. They point out, however, that results were generalizable across the two separate research settings.

320.

Liss-Levinson, Nechama; Coleman, Emily; and Brown, Laura. A program of sexual assertiveness training for women. ***The Counseling Psychologist*****, 5(4):74-78, 1975.**

A program of sexual assertiveness training for women is described. The program has its roots in sexuality awareness training, sexual dysfunction counseling, assertiveness training, consciousness raising, and rape-action research. The authors suggest that the different socialization women undergo makes sexual unassertiveness a much greater problem for them than for men. They have learned from their own lives and in their work as counselors that women are unable to turn down sexual advances and to ask directly and assertively for what they desire sexually. Since many women tend to be out of touch with their sexuality, there is often an ambiguity about what is wanted sexually. The primary goal of this sexual assertiveness training program was to provide women with the skills they needed to assert their sexuality and to clearly communicate their desires and needs. Goals described as associated with this primary objective are accepting one's sexuality, developing an awareness of one's personal, social, and sexual needs and desires, and acquiring an ability to be comfortable using sexual terms through the process of desensitization. The authors believe that women's ability to be sexually assertive will help to establish more mutually satisfying sexual relationships. Two sexual assertiveness training groups were conducted for 1- to 1½-hour periods each week for 6 weeks with eight participants and two facilitators in each group. Specific descriptions are provided of what occurs in each week's session, including times required for the different physical and role-playing exercises and discussions and the homework tasks that are assigned. The general purpose of each of the six sessions is identified as follows: (1) to introduce participants to assertiveness training concepts and desensitize group members to the use of sexual terminology; (2) to promote an awareness of the group members' likes and dislikes in social-sexual situations; (3) to learn to say no to both reasonable and unreasonable social-sexual requests without feeling guilty; (4) to introduce the idea of sexual satisfaction as a right and discuss and learn ways of asserting oneself in order to get it; (5) to build the assertion skills that are needed to initiate social-sexual encounters or activities; and (6) to learn what one's rights are during a gynecological examination and get some practice in asserting them. The sixth session was concluded with a group evaluation. Noting that an outcome study of the groups was underway at the time this article was published, the authors report that they found the immediate reaction to the training to be very favorable. The completion of homework assignments which were discussed at the beginning of each session indicated that the training was successfully generalized for use outside the group. Additionally, a great deal of trust developed within the groups. The authors comment on the aptness of the remark of a participant who reported that she learned two new words — "I" and "no" — as a part of this sexual assertiveness training program for women.

321.

Osborn, Susan M., and Harris, Gloria G. ***Assertive Training for Women*****. Springfield, Ill.: Charles C Thomas, Publisher, 1975. 204 pp.**

This book on assertive training for women is derived from the authors' clinical experience and is, in part, anecdotal. Although primarily directed to mental health professionals seeking new methods of intervention, the book is nontechnical enough to be useful to nonprofessionals. In Chapter 1, "Assertion and the Women's Movement," the authors review how women are conditioned to accept constricting social roles that are usually submissive in nature. Women are identified as having minority group status. They can either accept this status, often at great social cost, or act assertively and be labeled as deviants. The work of Chesler and the Broverman et al. study (1970) on double standards in mental health are cited. The authors note that the women's movement has been responsible for a reexamination of modes of help and formulations concerning mental health. Assertive training is presented as one of the new techniques that is proving especially helpful for women. Chapter 2, "Aggression, Assertion and Power," looks critically at the concepts associated with the development of assertiveness. Variations in the meanings of assertion and aggression are summarized, and the literature on power is reviewed. The negative view of aggression as related to doing violence or injury to others is criticized as an extremely narrow definition of the term. Chapter 3, "Foundations and Basic Techniques," presents the basic assumptions that underlie assertive training, its historical roots, theoretical explanations, and learning-theory base. Some of the techniques described in this chapter are relaxation training, hierarchy construction, behavior rehearsal, modeling, and coaching. In Chapter 4, "Assertive Training in Groups," attention is on the advantages of using a group for assertive training as well as the principles of group dynamics. There is also a section on the importance of recognizing group development phases based on a five-stage model. Specific guidelines are provided for trainers. Chapter 5, "An Innovative Approach to Assertive Training," discusses a variety of group techniques and procedures that can expand the framework of assertive training beyond its learning-theory base. Detailed instructions are given on how to conduct a 10-week series of assertive training sessions. "Areas of Application," the sixth chapter, deals with the application of assertive training to four specific areas — improving the social interactions of women living alone, enhancing a woman's sexual functioning, entering and getting ahead in the job market, and relieving depression. The focus of Chapter 7, "Risk Training and Change," is on the shifts that will occur in a woman's life when she makes rapid changes in her attitudes and overt behavior. Suggestions are given for dealing with the problems created by negative social feedback. The authors indicate that assertive training has far-reaching social implications. An appendix provides several materials that can be used in conducting assertive training.

322.

Rathus, Spencer A. An experimental investigation of assertive training in a group setting. ***Journal of Behavior Therapy and Experimental Psychiatry*, 3(1):81-86, 1972.**

Individuals who lack a repertoire of appropriate assertive behaviors and fear social confrontations may be unable to express their feelings or obtain fair treatment. Rathus suggests that such individuals might be helped by assertive training. To investigate this possibility, he randomly selected 57 junior and senior college women from among over 70 women taking adolescent or social psychology courses who had indicated a desire to change their behavior in the direction of increased assertiveness. The subjects were randomly assigned to three groups. The 18 assertive training subjects received training once weekly for 7 weeks and were instructed to practice and carry out specific tasks each week. Nine types of assertive tasks that were discussed with the subjects are identified and described. The 18 discussion group subjects met weekly for 7 weeks to learn about the nature, acquisition, and elimination of fear. The 21 control subjects had no treatment. Rathus reports partial confirmation of his two hypotheses that assertive training subjects would report and exhibit more assertive behavior and would report greater reductions in the fear experienced during social confrontations than would discussion group or control subjects. Assertive training subjects had significantly greater gains in assertive behavior than control subjects on the Rathus self-reporting assertiveness schedule but insignificantly greater gains than discussion group subjects. There was no significant difference in reported gains in assertiveness between discussion group and control subjects. Five subjects from each group were also given blind evaluations on 5-point Likert scales of their responses to five questions about what they would do in situations where assertive behavior would be useful. Assertive training subjects showed more assertive behavior than the other groups and discussion group subjects had more knowledge of fears, but these differences were not significant. Pre- and posttests on the Temple Fear Survey Inventory indicated that assertive training subjects reported significantly greater general fear reduction and insignificantly greater reductions in fear of social criticism and competence than control subjects. Discussion group subjects did not differ from controls. In discussion Rathus concludes that these findings may be generalizable to clinical populations since the reasons for nonassertiveness in both are probably the same.

323.

Rathus, Spencer A. Instigation of assertive behavior through videotape-mediated assertive models and directed practice. ***Behavior Research and Therapy*****, 11(1):57-65, 1973.**

The problem of nonassertiveness has been addressed differently by various schools of therapy. Psychoanalytic thought stresses repressed early learning experiences and resultant guilt; Rogerians attribute causality to conditional parental regard. In this article, Rathus reports on his investigation of a standardized learning approach. He hypothesized that subjects who observed videotapes of assertive models and practiced assertive responses would have increases in self-reported and other-rated assertiveness and possible decreases in fear of social conflict. The subjects, 78 female undergraduates, were randomly assigned to three groups. Assertiveness training subjects viewed model videotape assertive models in seven weekly 1-hour sessions and practiced nine assertive behaviors at home. Placebo subjects watched videotape models of desensitization procedures; no-treatment controls merely received pre- and posttests. Scores on the Rathus Assertiveness Scale revealed a significant ($p < .01$) increase in assertiveness in the assertiveness training group compared to placebo and no-treatment groups, which did not differ significantly from each other. In audiotaped question and answer sessions, 16 subjects, randomly selected from each of the three groups, were asked five hypothetical questions regarding what they would do in situations in which assertiveness would be profitable. The audiotapes were then rated by graduate students. Assertiveness training subjects were rated as significantly more assertive ($p < .01$) than the other two groups. Fear of social incompetence and social criticism were evaluated by the Temple Fear Survey Inventory, which revealed a nonsignificant trend for assertiveness training subjects to report lower posttreatment fear of social conflict than the other groups. Rathus concludes that nonassertive behavior can be modified and fears and inhibitions reduced on a fairly short-term and economical basis.

324.

Wolfe, Janet L., and Fodor, Iris G. A cognitive/behavioral approach to modifying assertive behavior in women. ***The Counseling Psychologist*****, 5(4):45-52, 1975.**

The authors directly relate the difficulties women have in asserting themselves to sex-role conditioning, which teaches them passivity and dependence as well as denial of self and devotion to others. Attempts to break out of this traditional sex role are often very painful. Women evaluate their behavior through their internal belief systems of how they "ought" to behave, and, when they act in a different mode, they often feel guilty and confused—thus reinforcing their lack of self-esteem. The clearly negative response of society to the increased assertiveness of women since the growth of the women's movement has intensified the anxiety of women about the problems assertion will create. The greatest block to assertion is identified as the set of irrational beliefs women have held since childhood that create fear and anxiety about losing people and hurting others. In assertiveness training groups conducted with close to 2,000 women over the past 2½ years, the authors determined that the approach's effectiveness depends on identifying and challenging these irrational belief systems. In their two-faceted program, poor assertiveness skills are modified with direct training using the traditional techniques of behavior rehearsal, modeling, and group feedback. Simultaneously, cognitive restructuring is designed to alleviate anxiety and negative feelings about assertiveness. A description of how the assertiveness training groups begin and work is provided along with a transcript of some of the members' statements about their problems in asserting themselves. The authors note that situations within the group are generated by the group members while the leader serves as a catalyst. A long transcript from a videotape used to show group members the differences between nonassertive, aggressive, and assertive behavior is included, as is a chart which is helpful in identifying and fighting the irrational beliefs that lead to nonassertive, hostile, or depressive behaviors. Both descriptions and samples of role playing are also included. *In vivo* homework assignments are considered a very effective part of the program, and these are accompanied with a related reading assignment from a work such as Ellis's *New Guide to Rational Living*. Both reports from women and a research study by Wolfe are presented as evidence that this rational therapy-oriented assertiveness training is far more effective in changing belief systems, decreasing anxiety, and modifying behavior than either consciousness-raising groups or a traditional behavior therapy approach. The authors conclude that their comprehensive approach is ideally suited to helping women to overcome their conditioning, to identify their own goals, and to begin to develop fully as human beings.

325.

Wolfe, Janet L., and Fodor, Iris G. Modifying assertive behavior in women: A comparison of three approaches. *Behavior Therapy*, 8(4):567-574, 1977.

The authors report on an experiment that compared the effects of a behavioral approach, a behavioral-plus-cognitive approach, and a group-process approach (consciousness-raising group) on helping women become more assertive. They hypothesized that the behavioral and cognitive/behavioral treatments would be more effective than consciousness raising in modifying assertive behavior and that the combined cognitive/behavioral treatment would be the most effective in reducing anxiety during assertiveness. The behavioral approach consisted of encouraging the modeling of actions plus behavior rehearsal. The behavioral-plus-cognitive approach added rational therapy to the behavioral approach. The group-process approach was a consciousness-raising group similar to groups led by feminist organizations. Women on a waiting list comprised a control group. Subjects were 64 women, aged 20 to 29, who had responded to a clinic notice announcing group therapy for women who had trouble asserting themselves. All of the subjects included in the study met the following criteria: they had a rating of 4 or less on a Global Self-Rating of Assertiveness Scale that ranged from 1 (extremely unassertive) to 6 (extremely assertive), and they had a score not more than 1.5 standard deviations above or below the mean on the Rathus Assertiveness Schedule. Two graduate students rated the women on two scales before and after treatment. One scale measured paralinguistic variations, such as firmness of voice and appropriateness of affect. The other scale measured assertive content of the subject's response. The behaviors rated were tape-recorded responses to videotaped situations that called for assertive behavior. Other tests given before and after treatment included the Rathus Assertiveness Schedule, the Social Avoidance and Distress Scale, the Fear of Negative Evaluation Scale, and a scale that measured anxiety. Subjects were assigned to matched treatment and control groups based on their pretest scores. These groups were randomly assigned to one of three treatments with one of two therapists or to the control group. Analysis of variance was used to test whether there was a significant difference between the four groups for each dependent variable. When a significant difference was found, Duncan's

Multiple Range Test was used to identify the specific groups which differed from each other. Groups differed in assertive content of behavior and scores on the paralinguistic scale. Women in the behavioral training and the behavior-plus-cognitive groups performed significantly better ($p < .01$) in the area of assertive content than women in either the consciousness-raising or the control group. The consciousness-raising and control groups did not differ from each other significantly. Women exposed to behavioral training and to the behavior-plus-cognitive treatment were significantly more improved ($p < .01$) as measured by the paralinguistic scale than women on the waiting list. Other differences on the paralinguistic scale scores were as follows: women in the consciousness-raising group were more improved than those on the waiting list ($p < .05$), but less improved than those receiving behavioral training and the behavior-plus-cognitive treatment ($p < .05$). Women in the four groups differed significantly in the amount of anxiety they reported feeling when they were assertive. Women in the behavior-plus-cognitive treatment group reported significantly less anxiety than women in each of the other groups. The authors suggest that their findings provide some empirical support for the increasing dissatisfaction of many women with consciousness-raising groups, which offer insight and sharing of experiences but not the actual tools for behavior change. They stress the value of using appropriate experimental design in studies comparing approaches for helping women become assertive.

Consciousness Raising

326.

Allen, Pamela. ***Free Space: A Perspective on the Small Group in Women's Liberation.*** **New York: Times Change Press, 1970. 63 pp.**

The intent of this handbook is to give women an idea of what the small group experience can mean. The author writes from her own personal experience in a women's group that came to define itself as "Free Space," because members were free to think and grow and develop new ideas as individuals within an atmosphere of trust. Allen believes that women are oppressed, are beginning to rise against this oppression, and have the potential to form a social movement of historic proportions. To be successful, they must first develop an ideology and learn to think autonomously. Allen attributes basic differences in the perception of men and women to the fact that women lack men's social and economic advantages. The author chose to write about the small group, because she feels it is a structure in which women can be freed to affirm their view of reality and to think independently of sexist values. Women can learn how their oppression operates and how it can be overcome both psychologically and socially. The first chapter deals with the growth of the group and the initial struggles and discoveries of its members. They came to realize that liberation could only be accomplished by combining the personal and the political. The second chapter deals with the concept of "Free Space" and the necessity of commitment for developing the trust required for the functioning of Free Space. The third chapter describes the small group process, carefully defining its four stages — opening up, sharing, analyzing, and abstracting. Identifying abstracting as the purest form of Free Space, Allen notes that her group has only begun to experience abstracting after a year of opening up, sharing, and analyzing. In the fourth chapter attention is on the individual's private needs for shelter, food, companionship, understanding, and sex; her need to do creative and socially relevant work; and finally her need for an ideological framework from which to operate. The fifth chapter focuses on the idea of a mass women's movement, now in its formative stage, that can change society. Its basic unit is presently the small group, and it is within the small group that women can develop an ideology and find perspective and support. Their needs, however, will only be met by a larger social movement. The sixth chapter presents a study plan that can give structure to group meetings. It is based on the four elements of women's condition as defined by Juliet Mitchell —production, socialization, sexuality, and reproduction. An appendix is included which is a collective paper written by the group's members for a women's liberation conference. It describes how the group, calling itself "Sudsofloppen," developed and what it has become.

327.

Brodsky, Annette M. The consciousness-raising group as a model for therapy with women. ***Psychotherapy: Theory, Research and Practice,*** **10(1):24-29, 1973.**

Brodsky focuses on consciousness-raising groups as a model for therapy with women. These groups have developed out of the "sense of restless constraint" some women feel in their life situations and the "awareness of being different and alone" others experience when they become involved in the battle against the stereotyped roles of women in this society. These groups have become an important aspect of the women's movement, for they have helped women to realize that they are not alone in their self-doubts and problems. Consciousness-raising groups are well suited to the exploration of identity issues. In the groups the women are confronted with acting as individuals; in the process of comparing personal experiences, the self-awareness of the group members is intensified. They become supportive of one another; they develop a sense of trust in other women and a closeness based on common problems. It is assumed that the environment plays a major part in the problems of the individual. The therapeutic process of these groups is similar to assertive training, personal growth groups, achievement-oriented training, or self-development groups. A problem arises when the group members try to use their newly discovered behaviors outside the group — with employers, lovers, husbands, old friends. When the new behavior is either ignored, misunderstood, laughed at, or retaliated against, the individuals involved or the entire group may become depressed, and a return to former behavior is likely. If the group survives this period, however, it can move from personal individual solutions to some sort of group actions. These actions to modify the environment give the group members a sense of both social and personal worth. Turning to the issue of the implications of consciousness-raising groups for the treatment of identity problems of women in therapy, Brodsky recommends (1) that therapists be aware of the increasing range of valid goals for healthy functioning of women in terms of roles and personality traits; and (2) that therapists recognize the reality of a woman's situation, the fact that discrimination does exist, and that there are things in a woman's life beyond her control. She identifies assertive training and independence from others, including the therapist, as essential for women in therapy. The therapist needs to recognize this and to be supportive of the woman's competence throughout the regressive and dropout stages of her battle. And, finally, just as with consciousness-raising group members, the woman can move on to direct action to improve the external world as a way of coping with her individual frustrations. Brodsky points out that a most important lesson to be learned from the success of consciousness-raising groups is that women can use other women as role models. In concluding, she reminds clinicians working with women that they must read the current literature and must be educated regarding the facts and reasoning of the women's movement if they are to be helpful to women.

328.

Eastman, Paula Costa. Consciousness raising as a resocialization process for women. *Smith College Studies in Social Work*, 43(3): 153-183, 1973.

Eastman traced the development of a consciousness-raising group during its first year. Her purpose was to learn more about the function consciousness-raising groups serve both for their participants and for contemporary society. Viewing the group process from the perspective of resocialization concepts, Eastman focuses on how the process of resocialization occurs. She points out that resocialization implies a break with the past and depends upon the woman's becoming part of a new group of "significant others" with whom she can share new meanings and norms. A history of the development of the women's liberation movement is provided along with a discussion of the concept of consciousness raising. Eastman notes that as women discover their common situation in the consciousness-raising process, feelings and politics merge. She describes four group processes in consciousness raising which appear frequently in the literature—opening up, sharing, analysis, and abstracting. Each consciousness-raising group is autonomous and leaderless in the sense that all members are considered responsible. The author then presents what is essentially a case history of a consciousness-raising group whose members were 11 middle- to upper-class married women with children. Over a period of 25 meetings from September 1970 to June 1971, the women progressed from being a loosely knit group whose members were generally ambivalent about consciousness raising and somewhat distrustful of one another, to a very caring, cohesive, and committed unit. They began to use their group as a laboratory for trying out new modes of behavior in relative safety as well as a source of verbal and emotional support. Although politics was never a major focus of the group, toward the end of the observation period, the members began to examine their personal issues in political terms and from a feminist perspective. An epilogue about how the women joined with other women in the movement when this group ended is also included. Lengthy interviews with the 11 group members were conducted in April and May. Although there were differences in style and perspective, all the women were enthusiastically positive about and had a "sense of fervent commitment" to the consciousness-raising process. Each woman could identify ways in which the experience had promoted personal growth or had been responsible for changes in orientation or lifestyle. The women reported gaining more autonomy, self-knowledge, self-confidence, and self-esteem and overcoming passivity as benefits of participation in the group. They commented on the new pleasure they experienced in identifying with other women and in developing caring and trusting relationships. Eight members perceived their consciousness-raising group experience as quasi-therapeutic, like a form of group therapy. Eastman concludes that her observations of the consciousness-raising sessions document the operation of a resocialization process in which members' views of themselves and the world were restructured.

329.

Follingstad, Diane R.; Robinson, Elizabeth A.; and Pugh, Marta. Effects of consciousness-raising groups on measures of feminism, self-esteem, and social desirability. *Journal of Counseling Psychology*, 24(3):223-230, 1977.

To assess the potential of consciousness-raising groups as an alternative to traditional counseling, the authors examined changes in self-reported profeminist attitudes and behaviors, self-esteem, and need for social approval in 34 volunteer women college students. The subjects were randomly assigned to (1) a 16-hour marathon consciousness-raising session, (2) eight weekly 2-hour consciousness-raising sessions (the time-spaced format), or (3) a no-treatment (control) group. To ensure equivalent formats, two female graduate students in clinical psychology functioned as facilitators of the group process in both the marathon and time-spaced groups. The structured group experiences focused on the following topics: body image, dating, love, marriage, motherhood, sex, male-female relationships, women's relationships with women, and life plans. Change scores on four scales — Attitudes Toward Women Scale, Feminism Behavior Scale, Expressed Acceptance of Self Scale, and Marlowe-Crowne Social Desirability Scale — were calculated for pretest to posttest, pretest to 30-day followup, and 1-day posttest to followup. The authors report that after participating in the consciousness-raising group experience, all experimental subjects had significantly increased profeminist attitudes and behaviors both at posttest and 1-month followup, but there were no significant pretest to followup changes in self-esteem or need for social approval for the combined groups compared with the controls. The time-spaced format subjects taken alone reported significnatly more profeminist behavior changes and had significantly more positive changes in self-esteem compared with the control group. However, the findings are inconclusive, since marathon group subjects had higher self-esteem. The authors conclude that the results indicate that consciousness-raising groups do fulfill a profeminist function but more work is necessary to determine their ability to effect personality change.

330.

Gerson, Barbara. Consciousness-raising groups with elementary school girls: A case study. ***Psychotherapy: Theory, Research and Practice*****, 11(1):30-35, 1974.**

Gerson reports on the consciousness-raising group she developed and led for fourth and fifth grade girls, aged 9 and 10. The six white, middle-class group members were selected simply because their teacher supported the idea. Attendance was voluntary, and the group met once weekly for 1 school year. It was hoped that the girls would come to understand their own experiences within a larger social context and to consider alternative modes of behavior. Gerson describes and compares the girls' consciousness-raising group to other services. She points out that a girls' consciousness-raising group differs from a women's group in that there is the difficulty of separating the girls' identification of themselves as females from their identification as children, and there is a leader present. The leader is needed to help the girls deal with their concerns as female children as well as to create a group in which the members are free to challenge one another and the leader. The major topic in both a girls' and a women's consciousness-raising group is that of the childhood experiences of being a girl, a sister, and a daughter. The additional topics focused on in the girls' consciousness-raising group were sexual behavior and relating with boys, dating and getting married, and these are elaborated upon. Gerson reports that despite their professed "liberated" attitudes on the pregroup questionnaire they completed, the girls did not really differ at all from more traditional girls in these areas. Their future goals focused on having a career as well as being a wife and mother, but their career choices were traditional. Gerson evaluates the consciousness-raising group, noting that on the basis of the more traditional beliefs professed by members during the year, it seems that the questionnaire measured only the most superficial level of self-report. It was her impression that the girls benefited more from discussions about their families and their current sexual conflicts than from discussions about future goals. Possible explanations for this are suggested. The girls are described as too young to be able to deal logically with the relationship between the individual members' conflicts and the surrounding sociopolitical values. Gerson reports that most of the girls felt that the group had made some change in their lives. They all identified the benefits of sharing their common experiences and of helping and being helped by other girls. She points out the need for systematic measurement of such variables as self-image, self-esteem, activity, and passivity before and after consciousness-raising group experiences. Suggesting the development of consciousness-raising groups for other young people, Gerson concludes that the consciousness-raising group is an appropriate way to help basically healthy girls deal with a changing society.

331.

Gornick, Vivian. Consciousness. *The New York Times Magazine*, Jan. 10, 1971. pp. 22, 77-82.

Gornick notes that throughout the United States women are having their consciousness raised and are beginning to view their personal experience in a political light. She offers examples of women whose consciousness was raised without ever participating in a consciousness-raising session. Consciousness raising is defined

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as the feminist practice of examining personal experience in relation to sexism. Underlying the growth of consciousness-raising groups are the following ideas: (1) that woman's position in society constitutes a social class; (2) that a woman's "natural" domain is her feelings; and (3) that testifying in a friendly, supportive atmosphere allows women to see that their experiences are not unique. The consciousness-raising group is presented as the most accessible introduction to the women's movement as well as the movement's most powerful technique for feminist conversion. Several women's and consciousness-raising groups are cited to illustrate the kind of breakthrough that occurs as participants come to recognize the similarities of their experiences and realize that their symptoms may be cultural rather than psychological. Gornick notes how her own preference for a strong unified feminist leadership gave way to an understanding and an appreciation of the small and highly personal consciousness-raising group as the "heart and soul" of the women's movement. The new psychology of self that is being forged within these groups makes the role of leadership unimportant. A transcript from a consciousness-raising group meeting in Manhattan makes up the major portion of the text. The group's 10 members were educated, primarily working women, none of whom were committed feminists. The group was in its third month of meetings, and the topic discussed on the evening reported was "Work." The transcript reveals much of the group's dynamics as well as the individual women's struggles with their background and their need to feel that they can function independently.

332.

Kincaid, Maylou Butler. Effects of a group consciousness-raising program on the attitudes of adult women. (Abstract source, *Dissertation Abstracts International*, 34(A):1082-1083, 1973.) *Dissertation Abstracts International*. Ann Arbor, Mich.: University Microfilms, No. 73-20448. 206 pp.

The expressed purpose of this study is to investigate the effectiveness of a consciousness-raising group program in changing the attitudes of adult women in a community college setting. Kincaid explains that the program was limited to women 28 years of age and older who had less than 60 hours of college credit and who had not been enrolled in college for at least the past 4 years. Forty-eight women volunteered and were randomly assigned to the experimental and control groups. The experimental subjects were then randomly assigned to the two treatment groups. Each consciousness-raising treatment group included 12 participants and 1 group leader who met for 16 structured 1-hour sessions and who focused on cultural role definitions, individual and group decision making, conflict resolution through role playing, goal identification, and the nature and quality of relationships. The control group received no treatment. Pretest and posttest measures were taken on criterion instruments for the entire sample: the Inventory of Female Values (IFV), the Personal Orientation Inventory (POI), and the Philosophies of Human Nature Scales (PHN). An analysis of variance procedure was used to assess the effects of treatment. Kincaid reports the following findings: (1) the experimental group in comparison with the control group did not reveal a significantly greater reduction in the discrepancy between the view of the real self and the view of the ideal woman (IFV), did not reveal signifícnatly greater movement from time incompetence to time competence (POI), and did not demonstrate a significantly more positive attitude toward other women (PHN); and (2) the experimental group did show significantly greater movement than the control group from an "other" to a "self-orientation" in the view of the real self and the view of the ideal woman (IFV) as well as greater movement from other directedness to inner directedness (POI); (3) there was no significant difference between the two treatment groups on the three criterion instruments; and (4) the positive-negative and multiplexity scores did not differ significantly for the standard administration of the PHN and the special administration on a women only basis.

333.

Kirkpatrick, Martha J. A report on a consciousness raising group for women psychiatrists. *Journal of the American Medical Women's Association*, 30(5):206-212, 1975.

This article focuses primarily on the effects of consciousness raising on a group of women psychiatrists. Kirkpatrick comments that initially women physicians did not respond eagerly to the women's movement. This particular group developed after responding to a questionnaire about their personal experiences during medical and psychiatric training. Initiated by the American Psychiatric Association's Task Force on Women, the questionnaire was sent to the women members of the Southern California Psychiatric Society in 1972. Twenty-one of the 98 women responded and, of these, 18 attended an initial meeting in which the possibility of establishing a consciousness-raising group was discussed. Eventually, a small

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number of women from the original 18 formed a group. At the outset, these women did not seem to feel the usual outrage experienced by nonprofessional women at the injustice of their status. Instead, they were drawn together by a sense of isolation from contact with other women. Meeting for 2 years, the group became quite homogeneous, consisting entirely of married, middle-aged, white, urban women. In their sessions, the women became aware that: (1) in their need to become physicians, they sought to be unlike ordinary women; (2) this desire emerged from their own internalized devaluation of women as competent people as well as from the actual limitations society places on women's achievements; (3) their apprehension about professional power leading to loss of their sexual power limited their own efforts for professional advancement and achievement; (4) they tended to accept men's rules about medical training and practice instead of working to adjust them to women's different modes of living; and (5) they resented male domination. The mutual trust and intimacy that developed in the group became a source of support for its members. Basic psychotherapeutic assumptions about the role of women, heretofore unquestioned, became open to question in a way that proved helpful in the members' own lives and increased their sensitivity to women patients. As an outgrowth of this group, new professional work on issues related to women has been initiated. Kirkpatrick concludes that the consciousness-raising group offers women physicians a unique opportunity for peer group feedback and support as well as a better understanding of themselves and other women.

334.

Kirsh, Barbara. Consciousness-raising groups as therapy for women. In: Franks, Violet, and Burtle, Vasanti, eds. *Women in Therapy: New Psychotherapies for a Changing Society.* New York: Brunner/Mazel, 1974. pp. 326-354.

Kirsh presents consciousness-raising groups as an alternative to traditional psychotherapy for women. Although women represent a majority of the population, studies demonstrate that women have many of the psychological characteristics of minority groups, such as self-loathing and low aspirations. This stems from their lack of access to power and the fact that traits defined as feminine are considered second rate in this culture. Women's shared realization of this injustice has created a social movement of which consciousness-raising groups are an integral part. Whereas psychotherapy works to enable the individual to cope with existing norms, consciousness-raising groups work to change the social structure and culture through the self-awareness of the individual. Consciousness-raising groups lack the hierarchical structure of the therapist-patient relationship. All members of the group function as equals. A group usually consists of 4-12 members who meet once a week for from 2 to 5 hours. The group's general purpose is to expand each participant's awareness of what it means to be a woman in today's world. Kirsh examines literature on consciousness-raising groups by first focusing on the stages that the consciousness-raising group moves through and then considering the individual changes that occur. She points out that in actual practice these phenomena may not be readily discernible as separate entities, for while the group must evolve in order for individuals to change, changes the members experience also motivate group transformation. Kirsh discusses four stages a group usually moves through (Allen, 1970): (1) opening up—during this stage a closeness results from sharing experiences and meeting with warmth and support; (2) sharing—problems are identified as caused by political and social realities, and group solidarity develops for working to solve them; (3) analyzing—ideology grows as the result of identifying the position of all women; and (4) abstraction—a continuation of analyzing. In the group women examine institutions and the group itself in order to determine how they need to be modified to support necessary change. A number of studies that focus on personal change in women's consciousness-raising groups have been conducted. The methods used to collect data in these studies are intensive interviews, participant observation, and questionnaires. Several of these research studies are discussed—including the work of Cherniss, 1972; Hotter, 1970; Micossi, 1970; Newton and Walton, 1971; Krug, 1972; White, 1971; and Whiteley, 1973. Among the changes in women reported in these research studies are changes in attitude toward self, more specifically, increased self-awareness, self-esteem, self-acceptance, and improved self-image along with a lessening of guilt and self-doubt; changes in perceptions of women and feelings about other women; and changes in reference groups, in interpersonal relationships, and in career orientation. The women Krug studied worked on the two main problems of relationships among women and the differences that occur in behavior when women interact with men as compared with behavior among women. After dealing with these personal concerns, Krug notes that the women moved on to political activity. Kirsh suggests that the data on women's groups reveal that when women are assumed to be competent, they come to think of themselves as competent. In learning to respect other women, women are found to gain more respect for themselves.

335.

Kravetz, Diane F. Consciousness-raising groups and group psychotherapy: Alternative mental health resources for women. *Psychotherapy: Theory, Research and Practice*, 13(1):66-71, 1976.

Kravetz asserts that society has a negative view of women and of the roles and values traditionally associated with women. This negative perception, which women internalize as members of society, has serious psychological ramifications. Anxiety, low self-esteem, and depression are common problems for women, and women are more likely than men to be hospitalized for mental disorders. The growth of the women's movement has brought about an increased awareness of the relationship between social oppression and women's personal problems. Criticism has been directed at the institution of psychotherapy, with its orientation toward adjustment within the traditional norms and its assumption that problems lie within the individual. Studies by Fabrikant (1973) and Broverman et al. (1970) are said to document the validity of this criticism. The hierarchical structure of psychotherapy and its neglect of problems created for women by social realities have also been criticized. Recent literature has encouraged therapists to increase their knowledge of research on sex differences and on the psychology of women, to reevaluate their own values and beliefs, and to increase the range of alternatives they suggest to and support for women. Consciousness-raising groups have emerged as mechanisms of change for many women, helping them deal with problems due to sex-role stereotyping and discrimination. Kravetz stresses the importance of studying consciousness-raising groups and examining what factors make them an alternative mental health resource for women. She discusses the ideology and structure of consciousness-raising groups and deals with specific aspects of these groups that are relevant to therapy, such as their dependence on personal experiences and feelings, their leaderlessness, and the positive change in personal attitudes and behavior that has been documented as an outcome of membership in a consciousness-raising group. The consciousness-raising group's consideration of personal problems as they relate to individual and societal factors has suggested use of its principles in psychotherapy. Citing studies focusing on this area of concern, Kravetz maintains that consciousness-raising groups and psychotherapy are similar since both are mechanisms for personal change and both use the group as the context for this change. However, the critical differences and relative values of the two models must be evaluated to make possible the identification of problems that require a trained therapist and those that might be best treated in a consciousness-raising group. Kravetz proposes five areas for empirical research; these deal with acquiring data on the occurrence and effects of sexism in therapy; on the outcomes of consciousness-raising groups and psychotherapy groups; and on the changes that take place in each. She expresses hope that research on sexism in therapy will lead to a nonsexist therapy and that subsequent focus will be on the relative effectiveness of psychotherapy and consciousness-raising groups. Women will then be able to choose psychotherapy if it is needed without fear of sexism. By the same token, they will have the option of turning to consciousness-raising groups as an alternative mental health resource. Thus both modes will be used, as appropriate, to bring about personal growth.

336.

Lieberman, Morton A., and Bond, Gary R. The problem of being a woman: A survey of 1,700 women in consciousness-raising groups. *Journal of Applied Behavioral Science*, 12(3):363-379, 1976.

A 26-page questionnaire was completed by 1,669 women who were current (66 percent), former (31 percent), or prospective (4 percent)* members of consciousness-raising (CR) groups. Respondents were primarily urban and suburban, white, and college educated, with a median age of 31. Responses were first compared to three non-CR samples from a previous study (Lieberman and Gardner, 1976) who had similar demographic characteristics and who were seeking help with personal problems. The authors report that stress was significantly higher in a group of women in psychotherapy, with no difference among the CR group, encounter group, and normative samples. The CR sample did have more self-reported symptoms of anxiety and depression than the normative sample. Factors that motivated women to join the CR groups were, in order of importance: interest in women's issues, help seeking, social needs, political activation, sexual issues, and curiosity. Most women in the CR groups who had had therapy experiences had found them helpful; this reaction was in contrast to the distrust of professionals found in other self-help groups and perhaps reflected the fact that most of the women were seeing feminist therapists. Respondents rated 16 problem areas that might be helped by the CR experience: problems with men were most often perceived as areas of potential benefit, whereas psychological problems were least often cited. In order of prevalence, areas in which women thought they were being helped by CR were: sharing commonalities, involvement, risk taking, insight, and role analysis. The authors attributed benefits gained from sharing common problems to the opportunity to acknowledge and deal with problems rather than the particular content of the problems shared. The women perceived little value in discussions of problems of discrimination and political issues, two of the three role-analysis items. Lieberman and Bond suggest that the basic CR approach is sound and that such groups are likely to continue, although with less emphasis on political radicalization. They indicate that CR groups, more accurately termed "support groups," are becoming more structured and quasitherapeutic and that membership is likely to increase because of proselytizing of participants.

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*Authors' figures add to 101 percent.

337.

Micossi, Anita Lynn. Conversion to women's lib. *Trans-action*, 8(1/2):82-90, 1970.

On the basis of biographical interviews and her personal experience in the women's movement, Micossi describes converts to the movement and the process of their conversion. Although converts to women's liberation are a disparate group, in Micossi's experience they all have two things in common—being Caucasian and having some college education. The conditions she believes are necessary for conversion are described and examples are drawn from interviews to elucidate them. To be ripe for conversion a woman must be aware of alternatives to the prescribed feminine modes of self-expression and developing self-esteem. This awareness may come from many sources. Once a woman realizes there are alternatives to the sex-role stereotype, she needs to see and feel the discrepancies between her actual circumstances and her potential. Since Women's Liberation identifies changing the system as the solution to oppression, women who become involved in it must have some knowledge of the potential of political solutions. Micossi also notes that a pattern of nonconformity is also necessary for conversion. The small group is the most common medium for conversion, and women usually join these groups after some significant event or encounter in their lives, such as the birth of a child or discrimination on the job. The first step in the conversion process is identified as articulating the problem. Through sharing their concerns, women come to realize that the problem is social rather than personal. After the problem is defined, it is explored by the group in all its subtleties. As it is revealed in increasing detail, a "change of consciousness" begins to occur; self-awareness is increased; and new insights are produced. Sex roles become invalid, and the normal flow of interaction is disrupted, so that the women must redefine themselves and create new forms of action. A reevaluation of one's past is also carried on, and a rise in self-esteem usually follows this new interpretation of one's self and one's life. Since society is to blame for problems, guilt and self-doubt dissipate, and many women experience new strength at this point in the conversion process. They redefine their significant others as well as themselves and find they have a new esteem for other women. Society is also redefined and the cultural ideals of marriage and maternity cease to be considered as the only means of fulfillment. Along with this change in thinking, a woman must modify her behavior to match her new definitions. The final step in the process of conversion is the woman's actively committing herself to some form of collective action. Micossi concludes that Women's Liberation is not just a political cause but a medium through which women can realize their full potential.

338.

Warren, Lynda W. The therapeutic status of consciousness-raising groups. *Professional Psychologist*, 7(2):132-140, 1976.

Using published consciousness-raising literature as a source, Warren attempts to clarify the therapeutic status of consciousness-raising groups. She describes the nature and purpose of the consciousness-raising group, identifying its nonjudgmental nature and emphasis on examining sexism and cultural conditioning. Consciousness-raising groups maintain a strong anti-therapy stance. They oppose traditional therapy's assumption that problems are individual and require personal solution; they object to its masculine perspective and tendency to diagnose sex-role unhappiness as psychopathology. Despite this opposition, however, testimonial evidence indicates that consciousness-raising groups have distinctly therapeutic effects. Reports tend consistently to identify the same factors as therapeutic outcome variables for group members — heightened feelings of self-esteem, greater intellectual and personal autonomy, increased self-awareness, enhanced feelings of commonality with other women, reduced feelings of loneliness or isolation, and growing realization that problems are not solely the result of personal failure or inadequacy. Additionally, the women acquire a greater understanding of how people are influenced by sex-role conditioning and expectations. This understanding often marks the beginning of positive emotional and behavioral change. There has as yet been no controlled research study of consciousness-raising groups that could isolate the factors responsible for their success. However, Warren suggests that 7 of the 10 "curative" factors Yalom (1970) identified as underlying successful group therapy are also evident in consciousness-raising groups. These factors are: imparting of information, instillation of hope, universality, altruism, imitative behavior, catharsis, and group cohesiveness. Only two of Yalom's "curative" factors are totally missing, and this is due to the specific direction of consciousness-raising groups, which will not concern themselves with the development of social skills or the recapitulation of the primary family group. Warren indicates that consciousness-raising groups clearly manage to bring about therapeutic change while simultaneously rejecting therapy's individualistic approach to problems. Consciousness-raising groups establish the accepting and supportive climate that is basic for the functioning of traditional group therapy. Although the women's movement values consciousness-raising groups for their political and ideological function, group members may consider their most important benefit to be personal change. The consciousness-raising group emerges from the literature as a new form of therapy for women as well as an alternative to traditional psychotherapy. Warren suggests that recognition of the therapeutic status of consciousness-raising groups is necessary if many of the misconceptions psychologists have formed about them are to be dispelled. She states that psychologists need to acknowledge the value of these groups and reevaluate their own work with women in view of the challenge they present. Finally, she suggests that such a reevaluation might help psychologists to refer women patients who might benefit from participation in consciousness-raising groups.

339.

Whiteley, Rita M. Women in groups. *The Counseling Psychologist*, 4(1):27-43, 1973.

Whiteley attempts to give readers a better understanding of the issues women are addressing in their group efforts to liberate themselves. She describes the focus of the classic consciousness-raising group and its antitherapy stance. Whiteley points out that the women's movement has moved on to an acceptance of women-only therapy groups and then discusses the purpose of these groups. A major part of the article is devoted to excerpts from a group formed by several women who are professional counselors. Their group developed following an unsatisfactory confrontation with their male colleagues. In the first excerpt, concentration is on the issues of "playing by men's rules" and always "checking it out with the man," with the women beginning to question men's systems for defining women's behavior and refusing to define what they are doing in men's terms. Other issues illustrated by the excerpts are as follows: (1) the way the culture's sexism works to deny women their personal power throughout their lives, leaving even achievement-oriented women subject to self-doubt and personal limit setting; (2) the role expectation brought to marriage that the man is superior and will take care of the woman and make all important decisions for her; (3) the serious consequences of socialization to play a secondary role on women who try to build their own sense of identity; and (4) the problems related to efforts to fulfill the traditional wife and mother role while being a professional and attempts to redefine household responsibilities. Also revealed in the excerpts are the insights the women achieved in their sessions. A concluding section deals with each woman's individual evaluation of the group experience. Major themes the women expressed were the gains they had made in self-respect as they came to respect other women and their increased self-acceptance as they learned their problems were shared by others. Whiteley comments that the excerpts make it clear that change and growth are not easy processes and the work to achieve them often creates pain.

Crisis-Oriented Intervention: Situational Crises of Women

Battering by Male Partner

340.

Martin, Del. *Battered Wives*. San Francisco: Glide Publications, 1976. 269 pp.

Martin investigates the problems of battered wives and offers some possible solutions. She explains that this complex problem involves more than the actual violence or the couple's personal interactions; it has its roots in historical attitudes toward women, the institution of marriage, the economy, the intricacies of criminal and civil law, and the delivery system of social service agencies. Focusing on the incidence of violence in the home, Martin notes that the issue has been so hidden that no real data on the incidence of wife beating exist. A chapter is devoted to the batterer, and an attempt is made to answer who he is, what are the underlying psychological and social causes of his behavior, and what triggers his behavior. The wives, who have provided most of the available information, describe him as angry, resentful, suspicious, moody, and tense, yet with an aura of helplessness, fear, inadequacy, and uncertainty. Battered wives offer many reasons and rationalizations for staying with the batterer, and the author identifies and discusses these—fear, sex-role conditioning, and economics. In two chapters Martin discusses the legal and the social service delivery systems. Although several courses of legal action and social service support appear designed to help the battered woman, Martin asserts that these systems produce pressure on the victim to endure her situation in the name of reconciliation. Recognizing that the criminal justice and the social service delivery systems will not quickly become responsive to the battered woman's needs, Martin suggests survival tactics — physical fitness, mental fitness, and divorce — so that the battered woman can protect and free herself from her violent domestic situation. Regarding mental fitness, Martin discusses

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the possible alternatives that may help a troubled woman regain a sense of her own identity, restore her self-worth, and provide the necessary support to make changes in her life: (1) individual psychotherapy with a feminist therapist who will understand the bias in the prevailing value system and will help her become autonomous in definance of that system; (2) a woman's consciousness-raising group which can help her confront her domestic situation honestly and which puts her in touch with other women who understand her circumstances and can offer her shelter in times of need; and (3) assertiveness training which provides the opportunity to learn to express the awareness gained in consciousness raising. In a chapter dealing with remedial legislation, Martin maintains that in order to effect a permanent change in attitudes, legislation making women equal with men in every respect is a necessity. Based on her review of all the supposed options available to battered women, Martin concludes that the development of shelters designed specifically for battered women and their children is the only direct, immediate, and satisfactory solution of the problem of wife abuse. Victims and their children need refuge from further abuse. The need for counseling or legal advice is considered to be of secondary importance. Martin describes each refuge that has been established in the United States and other countries and summarizes the lessons learned from their experiences.

341.

Nichols, Beverly B. The abused wife problem. *Social Casework*, 57(1):27-32, 1976.

This article examines the aspects of wife abuse that are pertinent to case workers and considers the concepts that tend to maintain a pattern of abuse rather than treat it. Additionally, treatment problems and issues are discussed. Nichols points out that social workers who lack instruction in, or a clear understanding of, the problem may take the stance that the wife has "asked for it." They may suppress their own identification with the woman and play down her experience. This behavior reinforces her lack of self-esteem and supports the system in which the abuse occurs. The patriarchal social system and the attitude that aggression is normal in men makes wife abuse an embarrassing issue; as a result, caseworkers often try to avoid dealing with it. Nichols believes that Freud's theory of women as masochists has been a crucial factor in the failure of casework intervention. She notes that women have changed and that a rigid adherence to this concept limits innovation in treatment for abuse. Legal issues also can create problems. Often workers instruct abused women in their legal rights but fail to assist them in acquiring these rights. Because police are reluctant to get involved in domestic violence, a woman may simply be placing herself in greater danger if she asserts her legal rights without some outside help. The problem of wife abuse among minority groups is also discussed. Nichols notes that understanding and respecting another culture, as social workers have been taught to do, does not mean that they should not intervene to keep one group within that culture from abusing another. The development of relevant treatment approaches to wife abuse will depend on whether social workers are willing to reexamine old theories and attempt new counseling techniques. Nichols recommends that the abused wife be referred to a consciousness-raising group or to assertiveness training to help her gain more awareness and a better sense of self-worth. Workers should familiarize themselves with the law and be willing to serve as advocates for their clients. Noting the difficulties that such efforts may encounter, Nichols recommends the development of programs for the abusers. Group treatment for couples involved in abusive interaction is also suggested and examples are given of how this can work. The author concludes that the most innovative work in wife abuse treatment is being done outside traditional family agencies by people involved in the women's movement. They have presented new options, such as shelters for abused women, self-help and consciousness-raising groups, and feminism as therapy with autonomy and self-esteem as its goals.

Breast Cancer

342.

Klein, Roberta. A crisis to grow on. *Cancer*, **28(6):1660-1665, 1971.**

Klein begins this article on the crisis of breast cancer in the life of the patient and her family with some discussion of crisis theory and efforts in the area of crisis intervention. Crisis has been defined as an insoluble problem brought about by stressful or hazardous events and responsible for the individual's loss of equilibrium. Several characteristics of a crisis that are important when considering the situation of the primary breast cancer patient are identified. The focus in this article is on the initial crisis in breast cancer, that of the primary operable malignancy which is treated with a simple or radical mastectomy. For the mastectomy patient to return to equilibrium, she needs to accept the loss of her breast by fully mourning the loss, to reintegrate a self-image deemed worthy of love and the benefits of life, and to begin to come to terms with the burden of potential recurrence of the cancer. Klein points out that social work has been responsible for developing and testing specific techniques of crisis intervention that are relevant to the breast cancer patient's crisis. The following recommendations for helping the breast cancer patient are offered and elaborated upon: help the woman to express her feelings and to sort out the real from the unreal, explaining as many times as necessary the facts about her diagnosis, prognosis, and treatment; refrain from giving false reassurances; assist the woman to anticipate her future and to understand how long her physical rehabilitation should take as well as her part in the process; counsel the family to understand the patient's feelings and express their own feelings; and help the patient to consider how and what to tell the significant people in her life, often her children. Discussing who can help the mastectomy patient, Klein describes a new method of team (nurse, physical therapist, social worker, and former mastectomy patient) intervention that reaches out to every mastectomy patient and is now an operational program at the Memorial Hospital in New York. Attention is also given to the issue of controlling conflicting overlap in patient care as the members of the professional patient care team become more sophisticated about the need to treat a patient's emotions as well as her body. She concludes that the doctor holds sanction and veto power, for when the other hospital staff members do not have the physician's cooperation and permission to share in the treatment, the patient often receives jumbled and conflicting messages. Additionally, Klein notes that it is preferable for a team to be functioning openly and in general agreement about how best to help a patient.

343.

Schain, Wendy S. Psychosocial issues in counseling mastectomy patients. *The Counseling Psychologist*, 6(2):45-49, 1976.

The focus of this article is on counseling mastectomy patients whose cancer is believed to have been arrested and who are more concerned about feeling emotionally and sexually handicapped than about dying. Schain notes the diverse population that is afflicted with breast cancer and suggests that counselors must

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recognize the multitude of problems that will arise related to individual factors such as age and marital status. To help women in need of psychosocial support, mental health professionals must be aware of the medical and epidemiological facts about cancers, the options available to women with the disease, and the specific problems and issues women who undergo radical mastectomy face. Listing the various stages women with breast cancer go through, Schain maintains that counselors must be aware of the specific problems that occur at each stage. She provides some basic facts and terms related to breast cancer, indicating that counselors must become familiar with these in order to understand the perceptions and experiences of women who have mastectomies. Schain reviews the literature concerning the possibility that psychosocial and sociocultural factors may contribute to the occurrence of breast cancer. She points out that in this society a woman's breasts are vital to her identity and sense of self-worth. Consequently, breast surgery brings social stigma, physical insult, and emotional trauma to a woman. Discussing reactions to surgery, Schain suggests that it is vital to know what factors within the individual are primarily responsible for her response to breast removal. Schain notes that supportive help is usually not available until after surgery. At that time, counseling must attempt to turn the traumatic situation into a growth experience by helping clients understand their reactions in light of their psychological and social histories. With the new awareness of women's options and right to "informed consent," Schain suggests that the emphasis for mental health professionals will be on presurgical intervention. Schain lists 14 concerns common to breast cancer victims. She identifies the problems these women must work through — accepting the loss of their breast by fully mourning it, reintegrating a self-image that is worthy of love and the rewards of life, and accepting the threat of potential recurrence. The author suggests that counselors who counsel mastectomy patients combine their own theoretical orientations with an understanding of rehabilitation counseling, sex therapy, assertiveness training, and the medical data on breast cancer. She describes eight major tasks inherent in the helping process: (1) helping the mastectomy patient to clarify her concerns and more subtle apprehensions and to rehearse anxiety-producing situations necessitated by mastectomy; (2) avoiding involvement in medical issues while keeping aware of the options; (3) remaining flexible to the patient's changing needs and adjusting therapy to suit her; (4) helping her examine and express sexual concerns;

(5) evaluating what types of therapy will be most useful and employing them; (6) being aware of one's own fears and needs relating to mastectomy; (7) recognizing that the loss of a breast may reactivate a previous experience of loss; and (8) being prepared to help all the significant others affected by the woman's cancer. Schain concludes that an effective cure for breast cancer must treat the woman's psyche as well as her body.

344.

Witkin, Mildred Hope. Sex therapy and mastectomy. ***Journal of Sex and Marital Therapy*****, 1(4):290-304, 1975.**

Witkin presents a psychosexual approach to the treatment of mastectomy patients and their partners. Her suggestions to the sex therapist are based on her own clinical experience and the personal experience of two mastectomy operations. She points out that for the mastectomy patient emotional suffering exceeds physical suffering. Problems in accepting and adapting to the loss of a breast are largely due to her fears of how others will react, and she is particularly affected by the response of her husband or lover. The task of the psychosexual therapist is to help the mastectomy couple overcome the alterations in their current sex life created by the mastectomy. Recommendations are directed to relatively well-adjusted couples who have a basically caring relationship and emphasize maximum emotional and physical closeness as soon as possible. The author suggests that the therapist adopt and communicate to the couple the belief that their relationship can be even better than before the mastectomy. The orientation of the psychosexual therapy approach is the psychodynamically and behaviorally oriented rapid treatment of sexual dysfunction as performed in the Cornell Medical Sex Therapy and Education Program. Witkin recommends that the couple be encouraged to remove the prosthesis during intercourse and exercises or, at least, discontinue its use after a short time. In other words, the psychological issues should be confronted early — each partner should express and share their fears and emotions. The author identifies and describes in detail two sex therapy exercises — body imagery and sensate focus — that have been modified to deal with both the physical and psychological factors of the mastectomy couple. Witkin recommends that intercourse be attempted as soon as possible (in the hospital or on the first or second day home), for early intercourse provides evidence of the husband's continued ardor and helps the woman toward a more rapid and complete acceptance of herself and her undiminished sexuality. If physical weakness or psychological fears interfere, the husband should still express his physical desire and caring. Positions that can be used during intercourse until the breast area has completely healed are provided to help the therapist guide the couple in the early stages of recovery. In discussing the aftermath of the mastectomy, Witkin relates that when the marital partners share their deep emotions aroused by the mastectomy, as encouraged by the therapist, permanent and beneficial changes in the individual and the relationship can occur, and these changes will have a positive effect on the woman's recovery. The author raises and deals with the question of how mastectomy may affect the unmarried or unpartnered woman and how the therapist can reassure this woman. Suggesting, contrary to some professional opinion, that psychotherapy may not be required for the couple with an open and ardent relationship, Witkin indicates that the decisive factor may be the relationship between the mastectomy patient and her husband, lover, or significant other in her life.

Pregnancy/Abortion

345.

Asher, John D. Abortion counseling. *American Journal of Public Health*, 62(5):686-688, 1972.

Asher discusses the objectives and principles of abortion counseling, the functions, selection, and training of abortion counselors, and abortion counseling in relation to other aspects of medical care. Helping the woman make and implement her decision about an unwanted pregnancy and assisting her in controlling future fertility are the counseling objectives. The three principles of abortion counseling are that counseling be freely entered into, that it be supportive and nonjudgmental, and that it provide the woman with information about the physical and emotional aspects of the procedure. The counselor's single most important function is to help the woman evaluate the alternatives and make her own decision. If a woman chooses abortion, Asher suggests that the counselor help her deal with practical concerns, such as a pregnancy test and gynecological examination, and with significant others if she desires; determine if there is a need for psychiatric referral; advise and refer for postabortal contraception; and provide followup for postabortal counseling regarding both contraception and emotional reactions to the abortion. The most important qualities for abortion counseling appear to be personality traits that include the basic counseling attributes of empathy, nonpossessive warmth, and genuineness along with a certain maturity, flexibility, and willingness to allow the woman to make her own decision. Additionally, the counselor should sincerely want to help women facing an unwanted pregnancy, regardless of the circumstances of the pregnancy, and should be able to tolerate ambivalence, uncertainty, and ambiguity. The author recommends the following concerning training procedures: (1) the opportunity to observe and then be observed or assisted by an experienced counselor; (2) some form of didactic presentation, including the basics of contraceptive and abortion technology, human sexuality, counseling, counseling techniques, and crisis intervention; (3) role playing; (4) group sessions for trainees — initially to provide the opportunity to examine some of their feelings about abortion, teenage sex, and sexuality in general and, later, as part of continued in-service training, to allow discussion of mutual problems and frustrations in relation to their clients; and (5) the availability of experienced personnel for consultation on a continuing basis. Asher points out that the abortion counselor will often be able to provide help to the woman in her contact with the physician who provides the abortion and postabortal contraception. The author furnishes a list of indications which suggest the need for referral to a mental health professional.

346.

Baldwin, Bruce. Problem pregnancy counseling: General principles. In: Wilson, Robert R., ed. *Problem Pregnancy and Abortion Counseling*. Saluda, N.C.: Family Life Publications, Inc., 1973. pp. 1-19.

This chapter sets forth a rationale and methodology for problem pregnancy counseling. Baldwin indicates that counselors must understand the dilemma a problem pregnancy creates in women and must realize that these women are often in conflict with themselves. An effective solution can only be accomplished within the context of the individual and her life circumstances. Problem pregnancy creates a choice-crisis and the decision of what to do should be made after all alternatives are considered. Consequently, alternative counseling is presented as the counseling model, and this type of crisis intervention is described in detail. When used in helping women with problem pregnancies, alternative counseling is characterized by (1) limited counselor-client contact, (2) emotional intensity, (3) the variety of circumstances present in each particular pregnancy, (4) the complexity of issues involved, (5) information sharing by the counselor who must be in command of varied and broad information, and (6) the necessity for the client to make a decision. Each woman must be helped to define and examine all aspects of her problem and the choices available to her so that she can make a decision. The issue of information exchange between counselor and client during various stages of the interview is thoroughly analyzed. In the first stage of information exchange, the counselor attempts to gather enough information to assess the woman's problem accurately. The second phase consists of organizing this information to better understand the client and her situation and relating it to the information she already has available. The third phase is sharing this information in ways that will help the woman deal with her attitudes toward, and emotional reactions to, her pregnancy and enable her to reach a decision concerning it. The author also discusses the importance of exchanging information in a followup interview. A section follows that is devoted to counselor skills that will maximize information exchange and communication. Baldwin notes that the counseling process is determined to a great extent by the personalities of those involved and how they interact and that effective counseling is usually developed as an ongoing process. With this in mind, he describes and explains the following techniques as they apply to problem pregnancy counseling — paraphrasing and restatement, responding to feelings, silence and nondirective leads, questions and questioning, self-disclosure, and interpretation. The issue of counselor development, or the integrating of self-knowledge with specific counseling skills, is elaborated upon. Baldwin indicates that counselors must make an effort to bring their personal assumptions about behavior and interaction into clear focus. The necessity for practicing counseling skills and developing skills in observation is also discussed. Role playing is presented as an effective learning method. In conclusion, Baldwin lists questions for consideration that concern central counseling issues adapted to problem pregnancy counseling.

347.

Bracken, Michael B.; Grossman, Gerald; Hachamovitch, Moshe; Sussman, Diane; and Schrieir, Dorothy. Abortion counseling: An experimental study of three techniques. *American Journal of Obstetrics and Gynecology*, 117(1):10-20, 1973.

The authors report on their study of 171 clients at a New York abortion clinic who were randomly assigned to one of three counseling procedures. In both the group orientation and group process approach, the abortion procedure and effective birth control methods were described to from four to eight women. Additionally, in the group process treatment, the counselor led the group in a discussion of several social and psychological issues raised by the abortion. In individual counseling, the counselor discussed the procedure with the woman and the birth control methods she preferred; she gently probed the woman's attitude toward the abortion, and dealt with other problem areas as the woman wished. Self-administered study schedules provided data on the circumstances surrounding the pregnancy (before counseling), reaction to the counseling session (after counseling-before abortion), and response to abortion (postabortion). The clients in the sample were quite young, mainly white and single, nulliparous, 8 weeks pregnant, and having their first induced abortion. Only 22.2 percent were actively practicing contraception at the time of conception. Considering the effect of counseling on the total sample, the authors report that the women who had individual counseling generally reacted most favorably to the counseling procedure. In contrast, on 10 of the 13 items developed to examine the client's response to abortion, those women participating in the group process treatment responsed more positively to the abortion. On three of the items women who experienced the group orientation treatment reacted more favorably. On all 13 items, those women who had undergone individual counseling reacted less favorably to the abortion than women who had experienced either type of group counseling. Two summary scales were developed to examine the interactions of age (15-20 vs. 21-45) with the type of counseling received on the response to both counseling and abortion. The overall response to counseling was quite positive among all women, and individual counseling gave the most satisfaction within each age group. Regarding reaction to abortion by type of counseling and age, the authors report that (1) within each age group, there were no significant differences in the reaction to abortion for the different types of counseling; and (2) for all types of counseling, the older women have the most satisfactory reaction to the abortion. The older group of women reacted most favorably to the abortion following individual counseling in contrast to the younger women for whom individual counseling predicts the worst reaction to the abortion. The age differences for individual counseling were significant ($p = .012$). Regardless of their age, women counseled by group process were more likely to indicate they would terminate future unwanted pregnancies by abortion; this finding was particularly significant in the younger age group ($p = .038$). The authors conclude that the most successful form of counseling differs between the younger and older women. They identify the need for research to replicate this finding in other clinic settings so that, if the result is found to be stable, all women will not be counseled with the same approach. They also suggest that clinics serving a large number of young patients should consider the use of group counseling.

348.

Burnell, George M.; Dworsky, William A.; and Harrington, Robert L. Post-abortion group therapy. ***American Journal of Psychiatry*****, 129(2):220-223, 1972.**

Postabortion group therapy was initiated in the Department of Psychiatry at Kaiser Foundation Hospital in Santa Clara in order to (1) help a woman resolve any residual conflicts about her unwanted pregnancy and the decision to have an abortion; (2) facilitate the referral for psychotherapy if indicated; and (3) inquire further into the woman's postabortion adjustment shortly following her discharge from the hospital. The authors report that 250 of 924 women who obtained abortions between July 1969 and July 1971 chose to return for the postabortion group therapy meeting 2 weeks after hospitalization. Five women would meet with a psychiatrist and a gynecologist for an open discussion; emphasis was on sharing information and feelings. Most women expressed a sense of relief from emotional tension, symptoms of insomnia, depression, and somatic complaints. The women usually actively participated in the meetings. They asked questions about the procedure itself and possible aftereffects, the fetus, and methods of birth control; most reaffirmed their decision to have an abortion; they discussed their motives for seeking the therapeutic abortion, methods of birth control to use in the future, concerns about confidentiality, and feelings that they had been punished for their sexuality. The authors identify ways in which the group was helpful to the women: (1) the combination of the therapists' nonjudgmental attitude and the mutual interaction in the group provided relief of anxiety from the social stigma of abortion; (2) the frank and open discussion dispelled the negative stereotypic view of abortion; (3) the question-answer exchange with the physician enabled the women to free themselves of many fantasies and misinformation about reproductive anatomy and psychology, birth control, sexual relations, and medical and legal facts about abortion; (4) the mixing of different ages and life situations promoted interactions within the group, and sharing experiences resulted in a mutual bond developing among group members; and (5) women with guilt and self-reproach were encouraged by the different reactions of other women to seek individual psychotherapy to resolve their problems. The authors note that improvement in the attitudes of the medical and nursing staff over this 2-year period were reflected in decreasing anxiety and guilt in subsequent groups of patients. Identifying the experience of the therapeutic abortion as an intense emotional crisis, the authors recommend that therapeutic abortion programs include screening as well as educational, therapeutic, and preventive aspects of gynecology and psychiatry.

349.

Canfield, Elizabeth. Pregnancy and birth control counseling. *Journal of Social Issues*, **30(1):87-96, 1974.**

The pregnancy and birth control group counseling procedures that were developed at the Los Angeles Free Clinic are the subject of this article. This service was developed in 1968, a few months following the liberalization of the California abortion law, in response to the many women with unwanted pregnancies who were seeking help. Identifying pregnancy counseling as one-session crisis counseling in the majority of cases, Canfield outlines and elaborates upon the areas of concern that need to be included in either the group or individual contact: (1) verification of intrauterine pregnancy; (2) complete explanations of the alternatives — interruption or continuation of pregnancy; and (3) discussion, questions, and comments which deal with failure to use contraception, failure of contraceptive method, sexual attitudes, the woman's concrete plans when she leaves the clinic, and the actual referral. The author points out that the Free Clinic's approach of first presenting basic information to the woman allows her to understand immediately that the counselor is knowledgeable and as unbiased as possible concerning the best alternative for each woman. As many women are just seeking information at this time, the able counselor is described as one who provides reassurance and support. Canfield also suggests that it is wise to encourage the ambivalent woman to discuss her problem with someone with whom she has a close relationship since feelings of isolation and loneliness are common at this time. Other guidance to the counselor includes the need to gently probe the woman about plans for raising funds, for sharing the news of the pregnancy with others, and for assessing realistically plans for pregnancy continuation. In her discussion of birth control counseling, which is provided in groups entirely separate from pregnancy counseling, Canfield outlines what the sessions should cover. Raising the questions of what is counseling, who should do it, and what are the necessary qualifications, the author offers guidelines for counselor selection. Observations of counseling sessions are identified as the most successful training method for counselors, but should be supported by thorough factual knowledge of the subject matter acquired by either formal or informal education.

350.

Donovan, Cornelia Morrison. Psychotherapy in abortion. In: Masserman, Jules H., ed. *Current Psychiatric Therapies.* New York: Grune & Stratton, Inc., 1975. pp. 77-83.

On the basis of her experience as an abortion consultant, Donovan discusses the use of psychotherapy in abortion counseling. She notes that most women can benefit from an opportunity to vent their concerns before an abortion and suggests that this usually can be handled by the gynecologist or a paraprofessional trained in abortion counseling. A review of the literature shows that many women experience a transient sadness, guilt, or regret in the first weeks following abortion, but these feelings pass quickly. The literature also reveals that women in the following situations have a greater possibility of postabortion psychiatric illness: (1) severe psychiatric illness; (2) failure of family to support the woman's decision; (3) abortion for medical reasons; (4) severe ambivalence; and (5) coercion by family or physician. She suggests that in cases where any of these situations exist, psychiatric consultation or brief therapy is good preventive medicine. Important issues should be raised by the counselor before the abortion procedure, for facing ambivalence after the fact causes helplessness and frustration. Donovan describes the preabortion interview, relating that the psychiatrist focuses on uncovering any unconscious conflicts that may have resulted in the woman's exposing herself to pregnancy. When these are clarified, the woman is better able to resolve her ambivalence and make a realistic decision. Examples are given of possible unconscious reasons for the occurrence of unwanted pregnancies in stable marriages where families were considered complete. In this situation it is important to see the couple together. It is necessary to determine if contraception was neglected because of emotional conflicts when women in troubled marriages become pregnant and seek abortion. Further counseling is indicated for these women, because pregnancy is only a symptom of their marital disorder. In the case of illegitimate pregnancies, the motivations of the women must be acknowledged so that they can make decisions on the basis of real considerations. Pointing out that with the adolescent the illegitimate pregnancy may be an expression of rebellion, Donovan recommends that adolescents be allowed to freely make their own decision about whether to have an abortion and that the entire family be treated in order to resolve conflicts. The most troubled women seeking abortions are those who have no relationship with their sexual partner, and they require good psychiatric care, whatever their decision. A sample abortion consultation is included; this is a standard psychiatric consultation with consideration of how neurotic patterns emerge around the issue of pregnancy. Donovan maintains that psychiatric difficulty after abortion is infrequent and provides an example of how an abortion may trigger previous difficulties. She concludes that a knowledge of abortion problems along with a knowledge of interviewing and treatment techniques will equip a therapist to practice the psychotherapy of abortion.

351.

Gedan, Sharon. Abortion counseling with adolescents. *American Journal of Nursing*, 74(10):1856-1858, 1974.

The focus of this article is on the special care adolescents require in abortion counseling. Gedan, who has counseled 400 women seeking abortion, believes that counselors working with adolescents must be willing to disclose their own feelings and experiences. This is because of the negative feelings adolescents often have toward authority figures. Openness on the counselor's part makes it possible for an interview to be a conversation between equals. To be effective, preabortion counseling must create an atmosphere that enables the adolescent to identify and express her emotional reactions. The heightened emotions and sensitivities of adolescence are discussed. Gedan believes that significant others in the pregnant adolescent's family must be included in counseling. She always interviews the patient's parents, both to help their daughter and to help them, since unwed pregnancy often creates crises in families. One important aspect of family counseling is to ensure that the patient accepts responsibility for the decision to have an abortion, since legally parents can impose their will on an adolescent daughter. The problem of the patient's involvement in destructive game playing with her parents over the issue of abortion is discussed. Gedan's techniques for penetrating such a game (e.g., the adolescent's claim that she wants to keep her baby but has been forced into having an abortion by her parents) are discussed. Contraceptive counseling is presented as an integral part of abortion counseling. In this area, as with all other aspects of dealing with adolescents, the counselor must be completely honest to create trust and not slant information to force a choice. It is important that adolescents be referred for birth control to physicians and facilities that are sensitive to their needs, so they can be helped to develop positive attitudes toward themselves as sexual persons in this period of growth. Gedan considers it vital to emphasize both partners' involvement in contraception. In concluding, Gedan writes that the counselor providing abortion counseling to adolescents must be aware of the law's view of their rights to medical treatment, noting that it may be necessary to become involved in political action to make appropriate care for clients possible.

352.

Kondaš, Ondrej, and Ščetnická, Božena. Systematic desensitization as a method of preparation for childbirth. *Journal of Behavior Therapy and Experimental Psychiatry*, **3(1):51-54, 1972.**

The authors report on their study of the use of systematic desensitization to prepare women with high anxiety levels for childbirth. They cite studies that have shown fear to be the most important source of pain in normal labor and work that has been done to eliminate this pain through psychoprophylactic preparation. The study posed the questions of whether psychoprophylactic preparation brings about reduction of fear and whether systematic desensitization is more effective in this respect. Forty pregnant women were divided into two matched groups. Their anxiety was measured using Taylor's Manifest Anxiety Scale (MAS) and a special fear survey schedule (KSAT) dealing with anxieties specific to childbirth. One group received the psychoprophylactic method and the other group was treated with Wolpe's method of systematic desnesitization. Treatments were conducted twice weekly in groups of from four to six members by the same therapist. The psychoprophylactic method sessions consisted of lectures, discussions, and physical exercises with full details about labor and delivery provided. For the women receiving systematic desensitization, information was only given in response to specific questions. The anxiety hierarchy was developed on the basis of the KSAT and direct questioning. Four to 5 weeks were spent in learning the Schultz method of relaxation, and desensitization took another 4 to 8 weeks. The psychoprophylactic method took approximately the same time as these two processes. Duration of labor, patient's overt behavior, and cooperation were recorded by an obstetrician. The KSAT and MAS were readministered after the completion of each course of preparation. Although both systematic desensitization and the psychoprophylactic treatment lowered anxiety, the differences in the MAS scores were only statistically significant for the women who underwent desensitization. The greatest decrease in anxiety specifically related to childbirth was also in the desensitization group. Further comparisons of the two methods show a statistically significant lower intensity of pain and shorter labor with systematic desensitization. When overt behavior during childbirth was compared, the differences between the two groups were statistically significant, revealing those women treated with systematic desensitization to be calmer. The authors believe their results demonstrate systematic desensitization to be of "superior potency" to the psychoprophylactic method for dealing with pregnant women with high levels of situational fear. The psychoprophylactic method diminished fear directly tied to childbirth but did not affect other anxieties as much as desensitization. Since the psychoprophylactic method proved less effective in this study than in the previous ones, the authors suggest that systematic desensitization for childbirth preparation may be preferable in cases of high anxiety. They note that their findings must be considered tentative until this research is replicated with the inclusion of other variables.

353.

Lieberman, E. James. Abortion counseling. In: David, H.P., ed. *Abortion Research: International Experience*. Lexington, Mass.: D.C. Heath, 1974. pp. 59-61.

Lieberman discusses the guiding principles of abortion counseling and the task of selecting abortion counselors. He bases his discussion on experience obtained as a psychiatric consultant to Preterm, a private, nonprofit, freestanding abortion clinic in Washington, D.C. The counseling done at Preterm is by women who are selected, trained, and supervised for this new type of service. Every woman who seeks an abortion is regarded as an ambivalent person. The task of the counselor is to assess both the internal and external forces that are moving the pregnant woman both toward and away from parenthood and to help the woman acknowledge her ambivalence and resolve it in the direction of her choice. This means accepting the complexity and difficulty of the decision and making the best decision possible. The decision should be based on complete knowledge of the alternatives and probable consequences and a clear understanding of what abortion involves physically and emotionally. Additionally, avoidance of future unwanted pregnancies is a major concern. In dealing with this area the counselor should determine the reasons for the pregnancy and whether the woman is adequately protected against repeated abortion-seeking behavior. The counselor must be a skilled interviewer and knowledgeable about contraception so that she can provide reasonable and sensitive advice. The counselor identifies her role with the woman as one of crisis intervention. The counselor may be able at this time of crisis to help the woman discover that the unwanted pregnancy reflects a self-defeating pattern of behavior. Also, the woman may use this crisis as an opportunity to reexamine her important relationships. Lieberman describes the present procedure of selecting counselors as an art. He identifies a good counselor as one who is capable of developing relationships quickly without overpowering or becoming too possessive of the woman. She is objective and supportive; can deal with lifestyles that are different from her own; can relate easily with physicians, nurses, and social workers; and can work with the significant others in the women's life. Reference is made to a recent study of counselor training and effectiveness which identified accurate empathy, authenticity or genuineness, and nonpossessive warmth as the essential counselor qualities. Lieberman relates that the importance of the role of nonprofessionals is growing in medical practice and that the Preterm experience supports this trend.

354.

McCarthy, Barry W., and Brown, Patricia A. Counseling college women with unwanted pregnancies. ***Journal of College Student Personnel.*** **15(6):442-446, 1974.**

A four-stage model used as a guide in counseling college women with unwanted pregnancies is the focus of this article. Indicating that crisis counseling with pregnant women is time-limited and goal-limited, the authors identify three counseling goals: (1) responsible and independent decision making; (2) avoidance of future unwanted pregnancy; and (3) use of the unwanted pregnancy as a learning experience. In the first session, stage 1, the counselor establishes a trusting relationship. By being supportive, objective, and sufficiently open to the fact that the client and counselor's lifestyle and values may differ, the counselor makes it clear that the primary concern is the woman's welfare. After establishing the role as helper and setting guidelines for confidentiality, the counselor takes a less active role and uses the client-centered techniques of empathy, positive regard, and genuineness. Focus is on facilitating the woman's exploration of her feelings about the pregnancy and the alternatives open to her. In stage 3, discussion of alternatives and development of a plan, the counselor initially gently insists that the woman have a pregnancy test. Discussion centers on planned sexual behavior and the use of contraception if the woman is not pregnant and on the advantages, disadvantages, and availability of each possible course of action relating to having an abortion or a baby, if she is pregnant. Once the woman is aware of the possible courses of action, the counselor needs to help her acknowledge and resolve any feelings of ambivalence or uncertainty she may be experiencing. In stage 4, carrying out the decision and followup, the woman needs to have at least one person in her environment who is aware of her situation and who will be available to provide help and emotional support. At the session that follows making the decision, any problems or questions that have subsequently arisen can be dealt with and concrete plans can be made. The counselor, by being supportive, reassures the woman of the importance of making a responsible decision that she will be able to live with later. If the woman decides in favor of an abortion, the procedure is explained, for this knowledge can work to substantially reduce the client's anxiety and fear. A followup appointment after the abortion or birth is always offered; this allows the woman the opportunity to express her feelings about the pregnancy, her future sexual behavior, and children. At this time, the woman should be helped to accept the fact of her experience. The authors conclude with the suggestion that counselors need to initiate and support primary prevention programs to reduce the high rate of unwanted pregnancies among college students and encourage the development of formal and informal courses in sexual behavior.

355.

Nadelson, Carol C. The pregnant teenager: Problems of choice in a developmental framework. ***Psychiatric Opinion*****, 12(2):6-12, 1975.**

The initial focus of Nadelson's discussion of the pregnant teenager is on the adolescent developmental process. This process is a complex series of physical and emotional changes occurring within a family system in which the reactions of one family member have a marked influence on the others. Nadelson points out that a pregnancy can be a way for an adolescent girl to announce her adulthood. It may occur when more subtle communications are missed or when parents do not facilitate separation. After briefly commenting on the necessity to consider and deal with the sexual activity of teenagers, Nadelson discusses the already pregnant teenager and her needs for sensitive counseling. The counselor should (1) acquire a developmental understanding of the teenager, which includes an assessment of her object relations, her capacity to function in stressful situations, her current home, school and work status, and her major ego resources and defenses; and (2) learn about and make contact with the people the teenager considers supportive. The actual counseling goals are facilitation of decision making, help in implementation of decisions, and assistance in future family planning. The importance of involving the family in counseling is also noted. Denial, inexperience, fear, and anxiety often may inhibit the teenager in seeking help. Moreover, coming to a decision about an unwanted pregnancy can be further complicated by the adolescent's regressive response to this stress. Nadelson identifies and discusses the issues which deserve emphasis when counseling the pregnant teenager — sexuality and sexual identity, ambivalence about pregnancy, fear, and loneliness and loss. Noting that the majority of adolescents can deal with the stresses of a pregnancy or abortion, Nadelson concludes that good counseling for an unwanted pregnancy can promote psychological growth. The essential task is the handling of the crisis, and the desired result is maturation rather than regression.

356.

Pion, Ronald Joseph; Golden, Joshua S.; and Caldwell, Alexander B. Prenatal care: A group psychotherapeutic approach. ***California Medicine*****, 97(5):281-285, 1962.**

The authors attempted to determine whether group psychotherapy could be used effectively in prenatal programs. Their objective was to deal directly with patients' anxiety. The study was based on the following considerations: (1) all pregnant women have substantial amounts of anxiety that will affect their labor and delivery as well as their mothering; (2) many sources of this anxiety can be readily discussed and understood and group therapeutic techniques can be used to reduce it; (3) such a program provides a practical means for teaching residents, students, and nurses how to deal with the emotional problems of pregnant women; and (4) the program does not neglect the many physical problems that may occur during pregnancy and requires no additional expenditure of time by the physician. Twenty-one women were selected to participate in the group therapy sessions, and 48 controls were selected from the outpatient obstetrics and gynecology clinic of the University of California Los Angeles School of Medicine. The 21 women were divided into 3 groups of 7. An obstetrical resident, a psychiatric resident, and two nursing instructors participated in the sessions. The Shipley Institute of Living Scale, the Minnesota Multiphasic Personality Inventory, and a true-false inventory pertaining to pregnancy, childbirth, and related attitudes were administered to some of the subjects and controls, and results of the testing are discussed. The true-false inventory revealed that the women had a positive interest in discussing their personal problems with their physicians. Considering the sample as too small to provide a basis for broad generalizations, the authors provide their subjective impressions. "Normal" pregnant women have many anxieties and multigravid patients need as much emotional support as first-timers. The sources of anxiety expressed in the meetings are discussed, and the authors report that this group method seemed to relieve anxiety. The meetings began with a set agenda, but, in a short time, patients were spontaneously discussing the topics of greatest interest to them, and the staff only participated as necessary. Most of the women became enthusiastic and cooperative about the meetings after an initial anxiety, and some experienced marked positive changes in attitude and a new awareness of the psychic causes of somatic problems. Even the women who remained uneasy and unenthusiastic about the group felt some diminution of their anxiety as their pregnancies progressed. On the basis of this experiment the authors conclude that group psychotherapy in prenatal programs appears to hold promise.

357.

Russell, Betty, and Schild, Sylvia. Pregnancy counseling with college women. *Social Casework*, 57(5):324-329, 1976.

The authors present a practice model they developed for working with the immature, sexually active college woman who resists contraceptive use and whose unwanted pregnancy is symptomatic of a pattern of problems in living. Of the 400 women helped with unwanted pregnancies at the Student Health Center (California State University, Sacramento) since 1971, 97 percent had some information about birth control and knew that contraceptive services were available at the Center. The authors present their clinical impressions, along with some case histories, to show that these women present a cluster of typical problems and that most of them are still dealing with the incomplete mastery of adolescent tasks. These women perceive themselves as powerless objects acted upon by others. They feel overwhelmed, suffer from low self-esteem, and struggle with confused and conflicting value systems. This results in a passive response to their own sexual needs and to the pressures exerted on them by others in their social environment. The authors' model for practice reflects their view that social work with these women should produce growth by increasing their ability to cope with their environment. They report that the initial interview usually occurs when pregnancy is confirmed, and the women present a high degree of helplessness. The social worker's task is to engage the woman in a helping relationship that will enable her to begin to take control of her situation. The client is involved in identifying the basic problem underlying her symptomatic pregnancy. As part of this process, her social, psychological, and biological status is explored. The worker shares in assessing the information so that the client will come to realize she is responsible for and can control the actions she will take to resolve her situation. In that the focus is on the life situation rather than on the pregnancy, the woman is able to see her pregnancy in perspective and to explore alternatives to her current situation. The worker should be careful to assign the decision-making tasks to the client while guiding her in a way that clarifies values and allows her to make decisions from a clearly articulated value system. The client is given an opportunity to master her earlier developmental tasks so that she can move into independent adult functioning. The authors report that 40 percent of the women they have treated for unwanted pregnancies were unable to cope with major areas of their lives. The fact that so many women have problems related to the noncompletion of developmental tasks suggests the value of further exploring practice models that can provide a growth experience for them. According to the authors, there is a crucial need for family planning programs that can identify these women and engage them in dealing constructively with their sexual activity.

358.

Sanders, Raymond S.; Wagener, J. Mark; and Thompson, Georgine E. Counseling for elective abortion. ***Journal of the American College Health Association*****, 21(5):446-450, 1973.**

Questionnaires were sent to women who had received counseling and referral services at the Oregon State University Mental Health Clinic and had subsequently had an elective abortion. The 48 women who responded (80 percent) had a mean age of 19 years, 8 months, at the time of the abortion (time since the abortion ranged from 6 months to 2 years). Only one subject was having academic difficulty at the time of counseling; three had received psychiatric treatment before coming to the clinic. The hypothesis that premarital pregnancy is a significant source of distress was verified — only 15 percent indicated they felt little emotional discomfort. However, after the State abortion law was liberalized, there was a significant shift toward less severe emotional reactions, and more women decided to have an abortion before coming to the center. The authors report that the more distressed the woman was, the greater relief she felt after her first counseling contact; only 20 percent reported no effect or adverse effect from the initial interview. Most (73 percent) of those who involved their families saw this as a positive factor. Moderate or strong negative emotions following the abortion were reported by 23 percent, whereas 31 percent reported basically positive aftereffects. Self-confidence and relationship to boyfriends were areas most affected. After abortion, use of birth control increased substantially, but frequency of sexual contact increased for only 35 percent. The authors conclude that the center's crisis intervention approach — stressing involvement of significant others, presenting and evaluating alternatives, facilitating decision making, providing emotional support and information — was effective. They recommend that the counselor, who may be a paraprofessional, recognize that the experience can dramatically affect lifestyle and self-concept but that good management of the crisis situation can result in a generally positive outcome in these areas. In localities where elective abortion is difficult to obtain, crises may be more severe and management should be modified accordingly. The authors suggest that future research should compare women who receive counseling with those who manage the crisis themselves.

Rape

359.

Abarbanel, Gail. Helping victims of rape. ***Social Work*****, 21(6):478-482, 1976.**

Abarbanel suggests that the needs of rape victims for medical care, professional counseling, and legal services can best be met by a 24-hour comprehensive service. The author, a social worker herself, identifies the training and experience of the social worker/clinician as particularly relevant to the treatment of rape victims, for it prepares one to deal with emotional trauma as well as to coordinate multiple services. She describes the model rape treatment program that has been established at the Santa Monica Hospital Medical Center under her directorship. Information dissemination is a vital aspect of this program because it demonstrates recognition of rape victims' needs and ensures maximum use of the service by the community. The program director trains all medical staff so that the mental health needs of rape victims can be integrated into the medical treatment they receive. Special care is taken to give rape victims priority treatment sensitive to their needs for privacy and a feeling of safety. Supportive services and counseling are available on a 24-hour basis to deal with the emotional trauma and social problems that rape creates for the victim and those close to her. Abarbanel points out that in counseling the rape victim, the social worker must be certain to relieve her of any sense of personal responsibility for the crime as well as to provide emotional support and information about her rights and options. Counseling for the victim and those other people who are vital to her support continues for 4 to 6 months after the assault in this model program. Staff training is identified as crucial, for all hospital personnel who come in contact with the rape victim and her family should be sensitive to their particular psychosocial needs. The need for coordination with other community agencies, efforts to educate the community, and program evaluation is discussed. Abarbanel concludes that unwillingness to report rape is a very important issue. She suggests that the community must be made aware of the availability of sensitive care, because it is reports of bad treatment that often keep women from seeking the help they need.

360.

Burgess, Ann Wolbert, and Holmstrom, Lynda Lytle. Rape trauma syndrome. ***American Journal of Psychiatry*****. 131(9):981-986, 1974.**

The Victim Counseling Program was designed as a cooperative effort between the Boston College of Nursing and the Boston City Hospital. Its objective was to provide 24-hour crisis intervention to women who had been raped and to study the victims' problems. Discussion of the immediate and long-term effects of rape is based on the analysis of the symptoms of a heterogeneous sample of 92 adult women who had been forcibly raped during the period from July 20, 1972, to July 19, 1973. The counselors were telephoned when a rape victim was admitted to the hospital emergency room, and they arrived within 30 minutes to talk with the victims. Followup was conducted through telephone counseling or home visits. The authors report an 85 percent rate of direct followup. Another 5 percent of victims were followed indirectly through either their families, police reports, or other service agencies who knew them. Detailed notes of the interviews, telephone calls, and visits were analyzed in terms of symptoms reported as well as changes in thoughts, feelings, and behaviors. Based on the analysis, the authors suggest the existence of a rape trauma syndrome—defined as the acute phase and long-term reorganization process that occur in response to a forcible or an attempted forcible rape. The syndrome includes behavioral, somatic, and psychological reactions. In the acute phase the woman experiences much disorganization in her lifestyle, and fear and physical symptoms are common. Two or 3 weeks later, the woman begins to reorganize her life, and at this time motor activity changes, and nightmares and phobias are prevalent. The model of crisis intervention used as a basis for counseling the women assumed that the rape represented a crisis in that the woman's usual lifestyle had been disrupted; that the victim was a "normal" woman who had been functioning adequately before the rape; that crisis counseling was the preferred treatment in helping women to return to their previous level of functioning; that counselors would actively reach out to the victims; and that counseling was not to be psychotherapy but was to concentrate on the rape as the priority issue. The authors discuss two variations in behavior, the compounded reaction and the silent rape reaction, and make suggestions for dealing with them. They report that the majority of the victims in this study were able to reorganize their lifestyles and to focus on protecting themselves from further assault. None of the victims revealed ego disintegration or bizarre or self-destructive behavior during the acute phase, although there were women who regressed to a previous level of impaired functioning from 4 to 6 weeks after the rape.

361.

Burgess, Ann Wolbert, and Holmstrom, Lynda Lytle. ***Rape: Victims of Crisis.*** **Bowie, Md.: Robert J. Brady, Company, 1974. 308 pp.**

Using personal testimony from 146 rape victims, the authors analyze and explain the counseling approach they developed in their first year of operating the Victim Counseling Program, a 24-hour crisis intervention service at Boston City Hospital. In the first two chapters the focus is on both the victim's and the rapist's view of rape. In the third chapter the authors describe the rape trauma syndrome—the immediate phase of disorganization following the assault and the long-term process of reorganization that occurs as a result—and specific with therapeutic techniques for dealing with the reactions to rape. The fourth chapter deals with the reactions of children and adolescents and their families to rape, while the three following chapters are devoted to the reactions of the community — the police, the hospital, and the various community programs for rape victims. The focus then moves to crisis intervention. The authors discuss crisis theory in relation to external and internal crisis, and they present data concerning the possible impact of the victim's age on the meaning the rape will have for her. Another chapter is concerned with the crisis requests or immediate needs of rape victims. The requests, grouped into the five categories of police, medical, and psychological intervention, control support, and uncertainty as to needs, form a common ground for communication between the victim and the counselor. After analyzing the initial interview as a primary therapeutic tool, its importance, and the need for having it as soon after the assault as possible, the authors discuss the specifics of the interview. They identify the areas that should be discussed with the victim and present interviewing techniques. Attention is next on situations that may create stalls in the interview process; these are usually caused by the counselor's feelings or handling of counseling tasks. Suggestions are made as to how these stalls can be overcome. The effectiveness of telephone counseling as an intervention method, and the implications of home counseling for the victim are dealt with in two separate chapters. Noting that the court appearance can often be as much of a crisis for the victim as the rape itself, the authors discuss how the victim is treated in court, the psychological stress court creates, how to counsel the victim as she goes through the court process, and the implications of testifying for professionals. The book's final section deals with counseling specific categories of victims — the adult victim, child and adolescent victims, male victims of homosexual rape, victims with prior psychiatric and social problems, and prostitute victims. In the chapter concerned with the adult victim, the authors provide four conceptual models used in mental health practice — the medical, social network, behavioral, and psychological models. They show how these apply to a specific case history and describe appropriate counseling skills.

362.

Fox, Sandra Sutherland, and Scherl, Donald J. Crisis intervention with victims of rape. ***Social Work*****, 17(1):37-42, 1972.**

The authors discuss the efforts of a community mental health center to provide crisis intervention during 1966 and 1967 to 13 rape victims within 48 hours of their assaults. The following responses were common to these women: (1) acute reaction, occurring immediately after the rape and usually lasting for several days; (2) outward adjustment; and (3) integration and resolution of the experience. Different interventions were developed to help the woman work through each period as easily and completely as possible. Immediately after the rape, the victim experiences feelings of shock, disbelief, or dismay followed by anxiety and fear. Fox and Scherl report that during this acute phase, the women were helped to talk and relate their feelings and were assisted in coping with practical matters such as medical attention, legal concerns, and the police. As the woman resumes her regular activities during the period of outward adjustment, the appropriate role of the worker is identified as support, not challenge. Nothing is done unless the woman specifically asks for help. In the third phase, when the woman usually becomes depressed again, the clinician reassures her that this reaction is normal and does not indicate serious emotional problems. Arrangements for counseling at regular intervals are appropriate, for it is during this period that the woman usually requires the most help in dealing with feelings both about herself and the attacker. Often, feelings of anger have been suppressed or rationalized, and the woman can use help in expressing and resolving this anger. During this third phase most women successfully integrate the experience, but all women should be reassured about the availability of resources for continued help if needed.

363.

Freiberg, Patricia, and Bridwell, Margaret W. An intervention model for rape and unwanted pregnancy. ***The Counseling Psychologist*****, 6(2):50-53, 1976.**

This article describes how the analytic grief process as originally posited by Freud can serve as a framework on which to base counseling for victims of rape and for women experiencing unwanted pregnancies. The termination of a pregnancy and a rape create a sense of loss in many women. The grief process consists of four interrelated stages — denial, depression, anger, and, finally, resolution. In the resolution stage, the other stages are integrated, and the reality of the situation is accepted. The authors indicate that the complete process needs to be experienced if future psychological difficulties are to be avoided; they note that anger is the most difficult phase for women in this society. Descriptions and examples from case histories are presented for each phase of the grief process in an unwanted pregnancy. Because society's reaction to an unwanted pregnancy creates many problems for women and because of the seriousness and finality of deciding to have an abortion, the authors consider it important that counseling be initiated as soon as the pregnancy is discovered. Counseling tenets to help in this decision-making process are presented based on the work of Tinnin and Bridwell (1972). Approaches for helping women trapped in one of the stages of the grief process are described along with a list of eight factors that might predispose a client to postabortion problems. The same structure is used to describe the grief process and counseling for rape victims. The literature has shown that rape victims go through stages and reactions very similar to the grief process. During depression, rape victims often blame themselves, and the authors suggest that they may find resolution by coming to the aid of other rape victims. They believe that it is important to establish a contact and provide support immediately after a rape, although the rape victim, in her denial of the entire event, may initially resist help. Freiberg and Bridwell emphasize the importance of helping rape victims to deal with their fear of the reactions of others to the crime, as well as the necessity of helping them verbalize all their feelings. They provide a list of six factors that would predispose rape victims to postrape problems. The authors conclude that the analytic grief process has proven to be a valuable framework in the counseling of white middle-class university students and, with modifications, could be generalized to other women.

364.

Hilberman, Elaine. *The Rape Victim*. Washington, D.C.: American Psychiatric Association, 1976. 98 pp.

This monograph on the female victim of forcible rape summarizes current knowledge about the needs and experiences of the rape victim and her family. It also provides a framework in which the clinician can more knowledgeably assist and support the victim. Hilberman initially focuses on the myriad myths and professional attitudes that until recently have been responsible for attributing blame to the rape victim rather than to her attacker. Research supporting the contemporary view of rape as an act of violence is reviewed. Also examined are sociocultural myths about the characteristics of the rapist and victim and the setting of the actual rape. It is noted that obtaining convictions for offenders by finding proof of the major elements of the crime is often difficult. A chapter and an appendix provide concrete guidelines for the medicolegal aspects of the rape victim's care. Hilberman deals with some of the specific problems encountered in the hospital treatment of the rape victim and includes guidelines for establishing crisis programs in a hospital setting. She points out that as part of a nationwide antirape movement initiated by women, community-based rape crisis centers have been developed. Their goals include providing supportive services to victims, reforming the institutions which deal with victims, education on rape-related issues, and reforming the law. Direct services to victims attempt to meet their need for information, emotional support, and advocacy. Peer counselors usually offer immediate temporary support and short-term followup. The counseling objective is the return of autonomous functioning and control. Individual counseling is the usual procedure; group models are reportedly less successful. Hilberman discusses reactions to rape, noting that some knowledge of crisis theory is basic to understanding the crisis which rape precipitates. In a chapter devoted to counseling and treatment considerations, the author identifies three common counseling assumptions: (1) crisis intervention facilitates working through the trauma and lessens the possibility of long-term psychopathological consequences; (2) the victim needs emotional support from whomever she comes in contact with during the crisis period; and (3) the rape is a crisis for the victim's significant others who also require emotional support. Hilberman also deals with the controversial issue of peer counseling versus professional mental health services. She identifies the need for police, medical, and psychological intervention and control, and summarizes appropriate areas for counseling intervention in the immediate phase. A chapter concerning the child rape victim is also included. Finally, Hilberman discusses the multifaceted role of the psychiatrist in the delivery of care to rape victims — a role with clinical, administrative, teaching, supervisory, and research aspects. She concludes with a summary of 11 research questions relevant to the rape victim which require attention.

365.

Notman, Malkah T., and Nadelson, Carol C. The rape victim: Psychodynamic considerations. *American Journal of Psychiatry*, 133(4):408-412, 1976.

The focus of this paper is on understanding rape as a psychological stress for the victim. Despite the different circumstances under which rape occurs, the authors point out that rape victims seem to share intrapsychic experiences. Rape generally heightens a woman's sense of helplessness and intensifies conflicts about dependence and independence. It also frequently generates self-criticism and doubt that may interfere with the victim's forming trusting relationships, especially with men. Rape is viewed as a crisis situation in which an external event breaks the balance between the internal ego adaptation and the environment. This is the kind of event described in the literature on stress. Stress reactions are defined as having four stages that also occur in rape victims — the anticipatory or threat phase, the impact phase, the posttraumatic or "recoil" phase, and the posttraumatic reconsitution phase. Each of these stages is described and related to what occurs with rape victims. The victim's response to rape is examined in terms of affect, unconscious fantasies, and adaptive and defensive ego styles. The authors note that rape victims rarely display any degree of direct anger, and this is discussed in psychiatric terms as well as in terms of societal norms for women's behavior. Guilt and shame are practically universal in rape victims and said to occur not only because the women feel that they could have handled things better, but because society focuses on the sexual rather than the aggressive nature of rape. The authors also discuss the response of men to rape, noting that the male partner of the rape victim is often threatened by the rape and unable to give the victim the support she needs. Notman and Nadelson point out that the rape victim must cope with some specific issues that are related to age and life stage. They focus on the issues rape may bring up for the young single woman, the divorced or separated woman, and the middle-aged woman. A change in the attitudes of professionals toward rape victims is identified. It is considered important to pay attention to the possible long-term effects of rape, such as mistrust of men, emergence of sexual disturbances, phobic reactions to situations that are reminiscent of the rape, and anxiety and depression that occur for no apparent reason. In work with rape victims, counselors should assess previous adjustment, including stress tolerance and adaptive resources, and should attempt to involve in the process people that the victim depends upon for support. The woman needs reassurance about how she dealt with the rape as well as her efforts to c[illegible] following the assault. Each woman requires a response from [illegible]unselor that is related to her individual life situation. She a[illegible]eds acknowledgment and counselor support in verbalizing and working through the complex problems she faces as a rape victim.

366.

Silverman, Daniel. First do no more harm: Female rape victims and the male counselor. *American Journal of Orthopsychiatry*, 47(1):91-96, 1977.

Silverman focuses on the difficulties inherent in a male helping a woman victim in crisis following rape. Counselor response, counselor identification, and the victim's response are discussed in the article. Silverman identifies several factors that can influence the quality of the male counselor's interaction with the woman rape victim: (1) feelings of anxiety the counselor may experience when asked to see a female rape victim may lead to his changing the intervention into a compensatory or corrective experience or to altering his techniques; (2) adherence to some of the same misconceptions held by the general public about rape may result in a tendency to focus more on the sexual aspect rather than on the inherent violence of the rape, and, consequently, undermine the empathic tone of his response; and (3) an unconscious wish to please female supervisors or peers may make the counselor overly gratuitous and patronizing in order to demonstrate that his attitudes regarding rape and women's issues are liberal. Silverman goes on to point out that male counselors may experience more difficulty in identifying with the female victim. He discusses the male counselor's unconscious objects of identification which may include the rapist as well as the husband, boyfriend, brother, or father of the victim and the form this identification may take. A profound sense of helplessness, powerful feelings of guilt and devaluation, and the displacement of anger are included among the victim's responses. Silverman suggests that the counselor be aware of these responses as he begins to interact with the victim, for these feelings may increase the difficulty of establishing a trusting relationship. Discussing the problem of the eroticized feelings that emerge for the victim counseled by a male as well as her sexual concerns, Silverman recommends the telephone followup as a way to give the woman some leeway in deciding on the future direction and intensity of counseling. The author suggests that the best way to deal with the responses of the rape victim is simply to let her know in that first contact that the counselor is sensitive, aware of significant potential conflicts, and available when needed. The author further suggests that the counselor should try to consider his personal values, beliefs, and identifications that might interfere with the communication of empathy to the victim, that he be both aware of and prepared for the sources of feelings that decrease the victim's capacity to trust others and begin a new relationship, that he examine his own understanding of what the crime of rape represents for the victim and for the rapist and familiarize himself with sociological and psychological studies on the subject, and that he participate in open discussions with female colleagues about their personal perceptions, experiences, and understanding of rape. Finally, he recommends that the male counselor attempt to involve members of the patient's support system in his intervention efforts, suggesting that helping the boyfriend, husband, brother, or father may promote the development of a truly supportive environment for the victim.

367.

Werner, Arnold. Rape: Interruption of the theraputic process by external stress. *Psychotherapy: Theory, Research and Practice*, 9(4):349-351, 1972.

This article presents the case of a woman who was raped during a period when she was a psychotherapy patient. The case is considered important because it presents an opportunity to use data gathered before and after the rape to put the event into perspective. It also provided the chance to develop and test an approach to treatment when the material being dealt with results from an actual tragedy rather than a fantasy. The patient was a 26-year-old graduate student who was in her second year of therapy when the rape occurred. She had been diagnosed as a passive-aggressive personality and was experiencing major difficulties with her female identity and with expressing aggression when therapy began. Before her rape, therapy had been progressing slowly. Following the rape, therapy changed from a leisurely discussion of relationships and fantasies, for the patient then presented a clinical picture similar to a grief reaction — insomnia, appetite loss, frequent crying, and fear of being alone. Her therapy then proceeded in several unique stages similar to those in grief reaction, each of which is described in some detail. The first stage was support and nurturance. Immediately following the rape, all efforts were directed toward providing the patient with kindness and understanding. She was then encouraged to recount the incident in detail. This was done over three therapy sessions and seemed to bring her relief from anxiety and guilt. The third stage of treatment dealt with reference to the incident. Although repeated reference is part of integrating an event into one's life, the therapist needs to intervene if the patient begins to use the incident to avoid facing life tasks. This was successfully accomplished with this patient. A recurrence of symptoms occurred when the patient had to appear as a witness against her attackers. The author notes that this return of symptoms can be, and was, used for further understanding and integration of the event. The patient was able to integrate the rape into her other life experiences, continue to deal with her poor self-image and feelings of isolation, and to assert herself. At a 1-month followup, the patient was doing well. After 3 months, however, she was experiencing some difficulty due to the uncertainty of her future in graduate school. The author relates that rape, in addition to being a personal assault, makes real a fairly common fantasy. Guilt based on this can be reduced through anticipatory guidance. Over a period of months, this patient was able to integrate the rape into her life as another significant event.

Widowhood

368.

Barrett, Carol Jeanne Clark. The development and evaluation of three therapeutic group interventions for widows. (Abstract source, *Dissertation Abstracts International*, 35(B):3569-3570, 1975.)

Dissertation Abstracts International. Ann Arbor, Mich.: University Microfilms, No. 75-1044. 220 pp.

Barrett reports on the development and evaluation of three therapeutic group interventions for widows. Seventy urban widows, ranging in age from 32 to 74 years and widowed for from 1 month to 22 years, responded to a news release and participated in either a self-help group, a "confidant" group designed to facilitate an intimate relationship with another widow, a consciousness-raising group, or a waiting list control group for a 7-week period. Two doctoral students in clinical psychology led each type of group. Psychological functioning, reactions to widowhood, lifestyle, and attitudes toward women were assessed at the pretest, at the final group sessions, and at a followup 3½ months later. The posttest comparison of controls and experimental subjects yielded a significant difference in change in predicted future health, favoring experimental subjects. Experimental subjects also revealed a greater decrease in other-oriented attitudes toward women than control subjects. Experimental-control group posttest differences did not occur on 10 other variables. Barrett reports that widows in all groups demonstrated increases in self-esteem and self-oriented attitudes toward women. The only reliable differences between the three group interventions occurred in the subjects' evaluation of the program and in the behavioral measures. The author indicates that although all responses were generally positive, the women in the consciousness-raising groups consistently gave the program the highest ratings of helpfulness and educational value and reported the most positive life changes during the 5- to 6-month evaluation period. Barrett suggests that the structure of this group modality for the approved expression of anger may have contributed to its success. In all groups, rates of contact between members were substantial but particularly high in one of the confidant groups. Four out of six groups chose to continue to meet as groups after the followup period. Barrett concludes that the women who benefited most from the program were the younger widows, the more recently widowed women, and those with the least preparation for widowhood. Directions for future research and much needed services for the widowed are outlined.

369.

Golan, Naomi. Wife to widow to woman. _Social Work_, 20(5):369-374, 1975.

Golan describes what has been learned about the process of widowhood as the result of efforts to assist Israeli war widows. Recently, at the request of the widows themselves, Israel began to use more paraprofessionals and other widows for giving assistance, because the personal involvement of the caregiver has been found to be more important than training. Golan identifies the first stage in widowhood as the shock of the physical and emotional loss. This is followed by a two-stage transitional process of moving from wife to widow and then to woman, able to be involved once again with other people. This transitional period is very difficult, and to successfully work it through a new widow must perform a series of tasks along two parallel lines. She must make material adjustments, such as new financial arrangements or physical living changes, along with psychosocial adjustments, learning to deal with her anxiety and her new social status. The widow needs first to accept the fact of death and break her ties with her dead husband and the past, channeling her feelings into "loving memories." During this period the woman should have the opportunity to express her grief and loss easily. Women with a religious or ethnic ritual for dealing with death found it easier to cope at this first stage. Subsequently, the widow must learn to live with the realities of her new status. It is during this period that a sense of aloneness and depression sets in, and it was found that talking to other widows was one of the most successful ways to learn to cope. In 1974 the Defense Ministry organized social interest groups of widows led by a social worker and a widow who had successfully completed her period of mourning. The women talked about their problems and developed their own language and jokes related to their adjustment difficulties. Golan reports that when the widow again feels competent and self-assured, usually between the first or second year, she begins to perceive herself not as a widow but as a woman with a future. At this stage, she may begin to reinvolve herself and become active in the community, may take some retraining course or obtain a university degree, and may consider relating to other men.

370.

Hiltz, S. Roxanne. Helping widows: Group discussions as a therapeutic technique. *The Family Coordinator*, 24(3):331-335, 1975.

Hiltz examines the nature of, and the problems involved in, the use of a group discussion technique with widows. Information is based on tape recordings of group sessions at the Widows Consultation Center established in Manhattan in 1969. The women leaders of this agency's group discussion program (a psychiatric social worker with experience in the area of bereavement and a psychiatrist who was recently widowed) identified the problems of the crisis of widowhood as expression and working through of bereavement (guilt, anger, depression) and development of a new identity. The group leader helps the members to gain insight into their feelings by offering some explanation of the psychological mechanisms involved. Quotations of the group leaders which focus on the difficulty of preexisting emotional problems which bereavement may exacerbate or bring to the surface are presented. Hiltz notes that the sharing of experiences and the immediate feedback from other widows are advantages of the group milieu over individual counseling and that, ideally, the group develops into a cohesive and supportive social unit. These leaders consider a fairly homogeneous group in terms of age, socioeconomic levels, and kinds of problems they have to be preferable, and 4 months to a year as the optimal length of attendance. Taped excerpts from actual sessions are presented to promote the reader's understanding of the process of the sessions and the problems that may arise. Followup interviews were completed with 55 widows and open-ended questionnaires were also used to elicit the reactions of participating widows to the sessions. Examples are given of both negative and positive responses. A description is provided of the well-known "Widow-to-Widow" project in Boston which uses peer counseling as the intervention technique. Hiltz points out that between the Widows Consultation Center and the Boston project three modalities of treatment have been used to help widows — individual casework by a professional, individual visits and counseling by another widow, and group discussions among widows led by a professional experienced with bereavement problems. She reports that all modalities of treatment have been judged successful by the organizations using them but that the data collected are neither rigorous nor comparable enough to allow comparisons of costs and outcomes. Hiltz concludes that the group discussion can be a very effective treatment modality. It can also prove useless or even detrimental, however, if the woman is unable to relate well enough to other group members and to the leader to allow the interaction process to help her understand and work through her problems over a period of time. A well-trained discussion leader who is able to deal effectively with the emotional problems of widowhood and the careful selection of participants are identified as crucial to the success of the program.

371.

Miles, Helen S., and Hays, Dorothea R. Widowhood. ***American Journal of Nursing*****, 75(2):280-282, 1975.**

Two psychiatric nurses describe the crisis intervention service they established for widows. The service's goals were to reduce pain, to prevent psychosomatic illness, and to help the women move toward new personal growth. The group format is discussed, along with the composition of their first group of 28 widows — women who differed in levels of education and economic status and whose ages ranged from the early thirties to the late fifties. Loneliness was the major current problem of these widowed women. Additionally, the most recently widowed women had difficulties in dealing with finances and plans for their children. Women who had been widowed 10 months or longer presented problems in becoming more self-confident and independent. A total of 12 groups have been formed with each group meeting once weekly for 2 hours over a 3-month period. The topics the widows select for discussion are classified into intrapersonal, interpersonal, and material problems. In discussing intrapersonal problems, the focus is on loneliness; feelings of being wounded, less of a woman, inferior, and incapable; and a sense of aimlessness. Dating and sexual needs, along with the difficulties presented by children, are the subjects of the interpersonal problem discussion. In dealing with material problems, attention is given to the concrete difficulties that arise with houses, cars, social security, a lower income, and preparation for and securing of new jobs. The authors relate that the groups move through two processess, first expressing feelings and difficulties and, secondly, recounting stories of constructive action taken to help themselves. The group response in both situations is supportive, and, in the latter instance, they provide approval and admiration. The authors recommend co-leadership as most effective with groups as large as theirs, limiting group membership to 16 to 20 women, and encouraging members to remain for all 12 sessions. At the end of the 3 months of group sessions, they suggest to the women that they form their own groups in order to receive and give continuous support and to explore social and recreational opportunities.

Feminist Therapy/Feminism as Therapy

372.

B., Evgenia; Dejanikus, Tacie B.; and Douglas, Carole Anne. How feminist is therapy? ***Off Our Backs*** **6(6):2,3,22,23, 1976.**

In a joint introduction, the authors relate that they eliminated their initial lengthy interviews with feminist therapists when they realized that they preferred to express their own personal experiences with therapy and their reactions to therapists. The authors identify mental health as a collective concern, and they share an interest in finding better ways for women to work together to help each other. Evgenia B., a former therapist, writes the first of three segments. She expresses concern with the contradictions involved in being a feminist and a therapist; therapy is a privilege in this society, and working as a therapist maintains a power relationship. She discusses both of these factors on the basis of her experiences as a client and a therapist. Noting that therapy can be useful for middle-class women and feminist therapy can help feminists with their struggles, Evgenia B. points out that most women are neither middle-class nor feminists. She presents peer counseling as an alternative to therapy. Because mental health professionals are given their power in service of the more powerful who wish to preserve the status quo, Evgenia B. concludes that women must reclaim their identity and power in their daily collective struggles rather than in "the closet of therapy." In the second segment, Tacie Dejanikus deals with her experiences as a consumer of intensive therapy. She reports on her positive therapeutic relationship with a nonfeminist therapist who kept her own values out of their contact, noting the lack of difference in the therapy offered by this nonpolitical psychiatrist and the feminist therapist she now sees. Although she criticizes the feminist therapist for being on a "power trip" to a certain degree, lacking consciousness in charging high fees, and encouraging individual solutions, Dejanikus contends that therapy has been a lifesaver for her and has taught her many useful things. She states her intention to continue with therapy while remaining aware of its problems and resisting those aspects

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of it with which she disagrees. In the final segment Carole Anne Douglas voices concern with the relativistic nature of "radical" or "feminist" therapy, claiming that feminist therapists assume that all options are equally valid, useful, meaningful, or desirable, although they supposedly operate out of a political consciousness and a desire to eliminate the oppressions that occur in traditional therapy. She criticizes her feminist therapist for attempting to interpret and direct feelings and for denying that her politics belong to her gut feelings. Political analysis and the discussion of personal problems are identified as complementary processes, and Douglas maintains that therapists should be very clear about their biases from the start. The self-fulfillment ethos held by feminist therapists is perceived as harmful to the positive interdependency that exists between women and the women's movement. Acknowledging that radical therapy is necessary at present, Douglas suggests that ideally friends would serve the function of institutionalized therapy. She suggests crisis counseling and an informal network of supportive services for women as alternatives to long-term therapy.

373.

Elias, Marilyn. Sisterhood therapy. ***Human Behavior*****, 4(4):56-61, 1975.**

Elias describes the growth and effectiveness of feminist therapy. The working feminist collectives formed in the 1970's as an outgrowth of the women's movement are identified as largely responsible for the proliferation of feminist therapy. Elias reports that these collectives have major similarities, although they differ in their financing and daily operations. Authority is equally divided and discussion is the means of settling problems. Modes of therapy may differ, but feminist therapists share the belief that mental health is not defined by specific behaviors for each sex. They try to help their patients move away from traditional sex roles and make decisions about what they really want. Feminist therapists are regarded as different from many humanist therapists in their belief that sexism is corrosive and growth-retarding, that sex-role conditioning must be understood so it can be overcome, and that the "personal is political." Elias describes feminist therapists as different from radical therapists only in the emphasis they place on the importance of eliminating sex roles that inhibit human growth. The collectives use various psychological techniques although most have a behavioral bent, but in their value system they are alike. Elias identifies the feminist therapy groups as different from the consciousness-raising groups from which they evolved in their concentration on emotional rather than primarily intellectual problems. An example of a woman who sought help at the Feminist Therapy Collective in Philadelphia illustrates how the principles of consciousness raising integrated with therapy techniques can work to bring about positive change. Including examples of changes experienced by women, Elias notes that a similar quality exists in the self-discovery descriptions of women in therapy collectives throughout the United States. An article by a San Francisco therapist, Hogie Wyckoff, is quoted concerning how women have been conditioned in self-denial and incompetence and how they are working to change this. Elias suggests that women's relationships with men may change or even dissolve because of the changes they undergo in therapy. In concluding, she notes that although women in feminist therapy develop their assertive side, they do not want to imitate the American male's emotional model. They want to integrate their new assertiveness with positive aspects of the feminine experience.

374.

Feminist Counseling Collective. Feminist psychotherapy. ***Social Policy*****, 6(2):54-62, 1975.**

The theories of feminist therapy and group counseling discussed in this article are based on 3 years of effort by the Feminist Counseling Collective. The collective was established in 1972 as a project of the Washington Area Women's Center to provide alternative counseling to women who regarded traditional therapy as insensitive to their specific problems and too expensive. It is hoped that the feminist therapy perspective will become part of the practice of all therapists so that women can be understood both in terms of their socialization and of their personal family histories. Sex-role stereotypes are identified as basic to American culture and as reinforced by American institutions. The 1970 study by Broverman et al. indicates that mental health professionals share in these sex-role stereotypes since they maintain different definitions for healthy men and healthy women. The concept of healthy adult coincides with that of the healthy man but not with that of the healthy woman. Consequently, a woman is doomed to failure, for she cannot simultaneously fulfill the contradictory ideals of both a healthy adult and a healthy woman. Feminist therapists reject all three ideal stereotypes — of the male, the female, and the adult. The members of the collective have observed women trying to achieve the two conflicting goals and have worked to help them understand this "no-win" situation, believing that women can only win by rejecting society's double standards and changing their goals. Examples of clients who manifest this conflict in different ways are presented. As women become aware of this role conflict, a "unified feminist ego ideal" that can be used as a new model is presented to them. This ideal is largely an integration of traits found in the healthy woman and the healthy adult for the purpose of constituting an adult woman. The feminist ego ideal is of "a strong and vulnerable woman" — a woman who feels free to function independently and to express her emotions and one who understands and appreciates her body and her sexuality. The authors explain that in feminist therapy the patient-therapist relationship is nonsexist and nonhierarchical. The therapists share themselves and their feelings and clearly state their values, demystifying both the process and the role of therapist; the need for a parent-like role is recognized, although it is believed that this can be accomplished in a nonhierarchical way; and the provision of a supportive environment in which women work together is regarded as vital. The tools and techniques of several types of therapy as well as of the human potential movement are used to help women achieve an understanding of their contradictory ideals and to allow them to explore new ways of being that are beyond their own experience. The Feminist Counseling Collective, in which all members are equal, is viewed as "a living model of an attempt to achieve a feminist ego ideal." The Collective generally functions as a group of 10 therapists and 10 trainees, both professionals and paraprofessionals who volunteer their time, and is strongly committed to training new feminist therapists. At the end of the article the training program is described.

375.

Hare-Mustin, Rachel T., and Robbins, Rosemary. How women and men relate to feminist therapy: A group discussion. *Voices*, 12(3):13-22, 1976.

This article is a presentation of a discussion that occurred during a Feminist Therapy Discussion Group led by Hare-Mustin at the University of Delaware. The group had been formed to discuss feminist therapy issues and to practice techniques through modeling and role playing. Although more people may have been present at this meeting, the discussion as printed included Hare-Mustin, Robbins, three other women, and six men. During the discussion, the women articulated their need to work through their problems in all-women feminist groups before they could move on to a broader humanism. The men expressed their difficulty with forming an all-male group and, generally, gave less import to the manifestations of sexist socialization pointed out by the women. After the open discussion, Hare-Mustin asked Robbins to summarize what impressed her about the discussion. Robbins cited the need for therapists of both sexes to examine themselves on as many issues as possible, using whatever method they prefer. She comments that the women, through their feminist group, have begun work on the hardcore problems of sexism but that the men seemed to be avoiding the issue on a basic emotional level. By dealing with the issues and consequences of sex-role socialization and by learning to share perceptions in a nonhostile way, this mixed group, Robbins concludes, is on the way to working through problems and perhaps finding new solutions for themselves, both as individuals and as therapists.

376.

Johnson, Marilyn. An approach to feminist therapy. ***Psychotherapy: Theory, Research and Practice,*** **13(1):72-76, 1976.**

The efforts of the Feminist Therapy Collective of Philadelphia to integrate feminism and psychotherapy are described. An exploratory study of its program to provide inexpensive psychotherapy to women is also reported. The program uses the time-limited contract method and relies upon group therapy as the preferred treatment mode. All members of the collective volunteer their time, and the therapists have been trained in either psychology or social work. Before entering group therapy, the prospective client participates in an intake exploratory group in which she, aided by six to eight women and two therapists, examines her current situation and need for psychotherapy. This procedure has the advantage of allowing a woman to participate in therapy-like groups before committing herself to therapy. Since beginning its program in September 1972, the collective has provided group therapy to 65 women, individual therapy to 13, and couples' therapy to 4. The exploratory study was designed to answer the following questions: (1) are clients similar to other women in therapy in terms of their complaints/problems and their level of pretherapy distress; (2) do clients using the collective improve as much as women in other therapies; and (3) what specific therapeutic factors do the clients consider most helpful? In order to respond to the first two questions, data on target complaints and client satisfaction were examined for 26 of 80 participants in a University of Pennsylvania Psychotherapy Research Study on psychodynamically oriented individual outpatient psychotherapy (Luborsky et al.). These 26 women were comparable in age and educational range to the collective sample. Their responses were compared to those of 24 women in the collective sample who had been assessed before and after therapy. Clients from the University of Pennsylvania had been in individual therapy with male therapists for an average of 10 months whereas the collective clients had been in group therapy with female therapists for an average of 4 months. Johnson reports that *t* tests on pretherapy scores, posttherapy scores, and change scores revealed no significant differences between the two groups. Both groups described similar problems when they began therapy (low self-esteem and troubled interpersonal relationships), similar levels of distress at that time, along with similar posttherapy improvement and satisfaction with the therapy experience. Johnson suggests that short-term group therapy in the collective setting was as effective as lengthier individual therapy in the clinic or private setting — at least according to the women's own evaluation concerning alleviation of their problems and satisfaction with therapy. Regarding the final question of what therapeutic factors are most helpful, a checklist of 20 items describing potentially helpful factors in group therapy was developed and administered to the collective clients. Eleven of the items were taken from Yalom's list of curative factors in group therapy, and nine were constructed to describe feminist therapy factors. The women generally considered the curative factors of group cohesiveness and universality to be the most helpful. They rated the following as the most beneficial feminist items: (1) perceiving the therapists as competent women; (2) knowing that women therapists have shared similar experiences; and (3) learning that other women are important and helpful. The need for future research on the transmission of values in therapy is emphasized.

377.

Kaplan, Alexandra G. Eight stages in the nine-month life span of a feminist therapy training group. *Voices*, 12(3):41-45, 1976.

Kaplan describes her 9-month group experience with women doctoral students who chose her as their supervisor because of her feminist orientation. She explores the impact of their identities as women, therapists, and feminists and also their academic setting upon the evolution of the group process. One of the issues stressed is the need to examine how feminist therapists are affected by the conflicts between feminist norms of support and sharing and the competitive achievement-oriented values of the academic world in which they function. Kaplan uses Erikson's sequence of developmental polarities as presented in his "Eight Stages of Man" as the framework for describing the progression of issues that this feminist therapy training group dealt with during its lifespan. She relates some of the discoveries that were made during this process: a shared ideology could not be equated with immediate trust and intimacy; members were unable to support each other when they had doubts about their own skills; and an intimate, sharing, and trusting relationship was a prerequisite for personal growth.

378.

Lerman, Hannah. What happens in feminist therapy. In: Cox, Sue, ed. *Female Psychology: the Emerging Self.* Chicago: Science Research Associates, 1976. pp. 378-384.

Lerman points out that it is the philosophy of feminist therapy, rather than its variable techniques, that differentiates it from other therapies. Feminist therapy is an outgrowth of consciousness raising and an extension of humanistic thought into the area of sex-role proscriptions. In feminist therapy the client is assumed competent, and the therapist does not adopt the expert role. Along with this assumption of competence, an assumption is made of the client's personal power — power to determine her own values, needs, actions, and thoughts rather than to allow others (as she has been trained to do) to make these determinations for her. Clients are taught to differentiate themselves from what has been socially proscribed and are exposed to the important philosophical position of feminist therapy: "the personal is political." As part of the process of differentiating themselves from social proscriptions and roles, the women are helped to develop self-esteem and self-confidence. This separation of the external and internal also helps women to realize that they are not crazy—a fear many women have because society so downgrades emotion and sensitivity. Lerman believes that it is important to help women validate their feelings. Anger is an important aspect of feminist therapy that surfaces when the client begins to assume her personal power, and the client will need help in positively channeling this anger. Self-nurturance is another vital part of feminist therapy — women must come to care about themselves enough to want to nurture themselves — they have been trained to nuture others. The therapist serves as a model of a woman who knows and respects herself and is also able to express gentleness. For this reason and because certain issues simply would not arise with men, Lerman suggests that women make better feminist therapists. She indicates that the goal of feminist therapy is not necessarily to create feminists—although a feminist consciousness is established—but to help women become the best people they can be within whatever limits they choose. This choice should made, however, after they have become aware of its alternatives and emotional cost. Lerman notes that there is no reason why men cannot be feminist therapy clients and therapists, since feminism questions traditional sex-role assumptions with the goal of helping people to be people without categorization. The author concludes by stating that although some feminists take a negative view of therapists and therapy, feminist therapy is clearly an outgrowth of, and belongs to, the women's movement and our times.

379.

Mander, Anica Vesel, and Rush, Anne Kent. *Feminism As Therapy*. New York and Berkeley: Random House Inc./The Bookworks, 1974. 127 pp.

A very positive attitude toward the therapeutic value of feminism is presented in this personal and political book. Therapy is defined as healing and feminism as a means of enabling women to become active and positive participants in society. In the first portion of the book, feminism is described as an antisystem — differing from other rigid *isms* in that it is constantly evolving — that stresses integration, a principle that has allegedly been shunted aside by the male-dominated industrial society. Feminism values the union of the rational and the intuitive, the subjective and the objective. Women are reevaluating their world and realizing the importance of unity and trust. The book's second part deals with feminist therapy which is identified as a consciousness-raising process. Mander and Rush criticize Freudian, Jungian, Reichian, and Gestalt therapeutic modes. They also consider the therapeutic value of political action, the benefits of finding out about one's roots and the contributions women have made historically, and the use of healing and body therapy. In the third part of the book a feminist revision of history (a discipline created and dominated by white males) and other academic fields is discussed, and readings from a feminist point of view are recommended. The authors indicate that the media, politics, and language are presently male dominated, but are in the process of being revised by women who are questioning the old values of objectivity over subjectivity. They note that feminism chooses the collective over the competitive, and this makes for a very different perspective from the dominant one in our society. In the final section, specific exercises for developing self-awareness are presented. These exercises focus on sex roles, responsibility, anger, understanding between daughters and mothers, female spirituality, and play.

380.

Marecek, Jeanne, and Kravetz, Diane. Women and mental health: A review of feminist change efforts. *Psychiatry,* 40(4):323-329, 1977.

The authors review the damaging effects social factors can have on women's psychological well-being and discuss four areas in which feminists are working to change the mental health system. Indicating that sex-role stereotyping, the traditional devaluation of the female, and institutional sexism have been detrimental to women's psychological health and personal growth, the authors point out that the society's mental health system, established to alleviate psychological distress, is riddled with the same biases that cause women distress in the first place. Consequently, it is highly unlikely that this system can be of any help to them. Feminist activism has focused on (1) formulating corrective theories of women's psychological health and disorder, (2) doing feminist counseling and psychotherapy, (3) establishing self-help groups, and (4) educating mental health workers to adopt nonsexist attitudes and behaviors. Feminists have exposed the male bias that underlies most traditional psychological theory and research about women. As a result of feminist concerns, biological determinism is being challenged and greater emphasis placed on how an interplay of biological, psychosocial, political, and economic forces works to form individual behavior. The authors suggest that new data concerning the effect of women's social situations on their mental health have profound implications for the treatment and prevention of psychological disorders. Feminist interests have also resulted in research on topics specific to women that were previously ignored. In working to change counseling and therapy practices, the authors report that feminists are primarily concerned with challenging the system of assumptions and values that forms the basis for professional behavior. Therapists must become aware of their beliefs about women and women's roles if they are to understand how these beliefs affect the treatment they offer. The differences between nonsexist and feminist therapy are delineated. While nonsexist therapy focuses on individual change, feminist therapy involves a critique of society and its institutions as a major element — social change is considered a necessary counterpart to personal change. Although the principles of nonsexist therapy with its acknowledgment of sexism and the effects of the social on the personal are essential to feminist therapy, they are not sufficient. Feminist therapy also uses treatment modes consistent with feminist principles; these include self-help, collective rather than hierarchical structures, and equal sharing of resources, power, and responsibility. The alternative self-help groups developed by the feminist movement, such as consciousness-raising groups, abortion referral services, rape crisis centers and mental health collectives, are discussed in terms of how they differ from the established mental health system. Although little systematic research has been done on self-help experiences, the available evidence suggests that they are providing a valuable service and the insights gained through them may lead to modifications in all mental health work. The authors report on the many efforts feminists are making to reeducate mental health workers because of their desire to change the traditional mental health system so that alternative systems will become superfluous.

381.

Pancoast Ruth Dreiblatt. "The Feminist/Unisex Ego Ideal: Its Function in Feminist Therapy." Paper presented at the 128th annual meeting of the American Psychiatric Association, Anaheim, Calif., May 5-9, 1975.

Pancoast presents a model for feminist therapy that she developed in her own practice and which is based on her belief in an unconditional value system — that each person has worth and is entitled to respect. From earliest childhood, boys are taught they are primary people who can map out their own lives; girls, however, are taught to find their worth through affiliations with others. Consequently, women develop no appreciation of themselves as separate persons. Although they learn to form connections with other human beings, this skill is not valued by society. Women need to recognize the value of their grasp on human connectedness while recognizing their own needs for effectiveness and autonomy. They need to free themselves from this conditional value system internalized during childhood that is geared to societally defined correct behavior. The therapist helps the woman in this task by making her aware of this value system and by loving her on the basis of the unconditional value system. When the patient learns that it is right to need and want, effort then must be focused on breaking ties to childhood conflicts where the conditional value system was established. As this is accomplished, Pancoast says that the patient is "reborn" and free to make her own way. It is at this point that the unisex ego ideal is identified as becoming important. The two modes of self-actualization — effectiveness (previously only available to men) and affiliation (once women's only path) — are integrated and recognized as vital to the achievement of humanness. Pancoast maintains that the patient needs to be able to choose from the complete range of human experience and not be bound by society's sex-role stereotyping if she is to achieve affiliation and effectiveness. She identifies the role of therapist as friend, parent, guide, and role model to her patient throughout the therapeutic process. According to the author, the most effective patient-therapist relationship is open, loving, and egalitarian. This therapy, feminist therapy, is different from humanistic therapy in that it questions social institutions based on sex-role stereotypes that devalue women and keep them from valuing themselves.

382.

Pyke, S.W. This column is about women: Feminist counselling: The new frontier. *The Ontario Psychologist*, **7(1):43-47, 1975.**

Pyke documents her prediction that feminist counseling will be legitimized within the next two decades and be incoorporated within the respectable mainstream of the counseling discipline. At present women make up the majority of the users of mental health facilities. Because society is changing and more role possibilities are becoming viable, Pyke suggests that cultural conditions are ripe for women to reevaluate their lives and seek alternatives. As they do so, more women will request some form of feminist counseling. Counselors have not been trained to deal successfully with the problems women are encountering, and this deficit has led to the growth of underground counseling services provided by nonprofessionals. Women who are articulately striving for their own liberation have much more credibility than the typical professional counselor. Some mainstream practitioners have begun to work with the underground effort, and the influence of feminist counseling is likely to be felt more and more because of its effectiveness.

The new counseling is concerned with education and emphasizes growth and development rather than adjustment. It is marked by an informality and a self-help orientation. The counselor's concerns are the same as the client's. Support and mutual concern are shared along with an indignation and desire to change the system to make it function better for women. Programs are designed for whatever problems women face. Rape clinics, career conferences, and assertiveness training are but a few of the feminist counseling programs. Pyke notes that feminist counseling has yet to develop its own theoretical orientation, although a commitment to social learning theory with its emphasis on human flexibility and the capacity for change seems to underlie it all. The feminists have been reviewing available theories and pointing out their inappropriateness for women. Pyke writes that although innovation takes more time than criticism, there are signs that new views on the nature of women "may blossom in profusion in the future." She concludes that this is all indicative of the movement of feminist counseling toward recognition as an integral part of the counseling profession.

383.

Rawlings, Edna I., and Carter, Dianne K. Comparative case analyses of sexist and feminist therapies. In: Rawlings, Edna I., and Carter, Dianne K. *Psychotherapy for Women: Treatment Toward Equality.* Springfield, Ill.: Charles C Thomas, Publisher, 1977. pp. 77-98.

Two case histories are analyzed in this chapter. The first case comes from a 1972 article in the *American Journal of Psychiatry* entitled "The Intractable Female Patient"* by John H. Houck, M.D. The intractable patient is portrayed as suffering from "borderline syndrome." She is immature, anxious, depressed, and angry. She is not easily controlled, and her "illness" is difficult to cure. A summary is provided of this patient's background, symptoms, and the ineffective initial treatment she was given based on Houck's article. Then, the treatment Houck proposes as effective is contrasted with treatment that would be offered in feminist therapy. The attributes Houck perceives as personal problems are identified by the feminists as societally induced. The intractable traits that Houck maintains need to be overcome are viewed by the feminists as signs of ego strength. Houck's therapy is regarded as authoritarian; his traditional values are only implied. In contrast, feminist therapy is presented as egalitarian in style with its feminist values made explicit. Houck recommends therapy that would have the patient achieve adequate feminine identity and resume her traditional role with a husband whom the therapist had helped to learn dominance. Feminist therapy would offer sex-role analysis that would enable the patient to see how traditional role expectations were related to her conflicts and would teach her that a healthy relationship is one based upon equality. The second case presented for comparison is drawn from the files of one of the authors (Carter). The authoritarian family therapy this woman, Sara, had previously received is contrasted with the feminist therapy provided by Carter. Sara had been led to view her strengths as pathological. The traditional therapists identified her problems as internally produced. In contrast, the feminist therapist attributed her problems to extreme external pressures. In this case, the treatment outcome that would have been viewed as a failure by the original traditional therapists was regarded as an outstanding success by Carter. She notes that at the time she worked with Sara, she had no awareness of a concept of feminist therapy, but, as she points out, her interventions, which went against her traditional training, were consistent with feminist therapy strategies.

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*Abstract of article included in this bibliography.

384.

Rawlings, Edna I., and Carter, Dianne K. Feminist and nonsexist psychotherapy. In: Rawlings, Edna I., and Carter, Dianne K., eds. *Psychotherapy for Women: Treatment Toward Equality*. Springfield, Ill.: Charles C Thomas, Publisher, 1977. pp. 49-76.

Feminist and nonsexist therapies are described and explained in this chapter. The authors initially establish that sexist therapy is destructive to women. They indicate that feminist and nonsexist therapies do not represent a particular set of therapeutic techniques. Basic to these therapies, however, is the idea that clients should be allowed to determine their own destinies without regard to fulfilling socially prescribed sex-role stereotypes. Both methods of therapy attempt to facilitate equality between men and women, although feminist therapy incorporates political values and feminist philosophy from the women's movement, and nonsexist therapy takes its egalitarian model from humanism. These therapies are equally valuable, but one may be more appropriate for a client than the other, depending on the level of the client's consciousness. The values that underlie nonsexist therapy, which are also incorporated in feminist therapy, are presented and explained. Self-awareness is expected from the therapist, and there is no differentiation in attitudes about similar behavior in men or women. The strategies used in nonsexist psychotherapy are also discussed. Ten values that are specific to feminist therapy, an outgrowth of the women's movement, are presented. Feminist therapy attributes woman's inferior status to the fact that she has less political and economic power than the male. Focus is on environmental stress as the major source of pathology, and personal adjustment to existing social conditions is opposed. Its goal is social and political change. Eighteen strategies that are based on the feminist therapy values are presented. The following are included among the strategies discussed: (1) the need for the therapist to make her values explicit before beginning treatment; (2) the drawing up of a contract that specifies what behavior the client wishes to change; (3) the teaching of how and when to use straight communication; and (4) the feminist therapist's commitment to engage in social action. Feminist therapy is identified as a reciprocal influence model, as posited by Argyris and discussed by these authors in the second chapter of *Psychotherapy for Women: Treatment Toward Equality*. Rawlings and Carter suggest that feminist therapy makes an important contribution to psychotherapy by detailing strategies that provide reciprocal consequences to the therapist and client. Presented in tabular form are the parallels between Argyris's model and feminist-therapy streategies and an analysis of the costs and benefits of fulfilling the traditional feminine role in contrast to fulfilling feminist values. Sex-role analysis is discussed as a therapeutic technique. The authors present the qualifications for feminist therapists — skill, expertise, and a commitment to a feminist philosophy. Although men cannot present a positive role model, the authors believe that nonsexist and feminist men can be qualified to treat women. Some cases in which men specifically should not treat women are discussed. A summary of the many psychotherapeutic techniques that are compatible with feminist therapy is presented.

385.

Williams, Elizabeth Friar. *Notes of a Feminist Therapist.* New York: Dell Publishing Company, Inc., 1977. 219 pp.

In this very personal book, Williams focuses on illuminating feminist issues in the psychotherapy of women and describing how a feminist-oriented therapist uses her perspective to help women in therapy. In the first chapter Williams defines feminist therapy and discusses why women are seeking this kind of treatment. She points out that feminist therapy goals are directed toward helping patients to increase their sense of personal power, self-esteem, and autonomy and to understand the connection between their cultural conditioning and their present psychological situations. Williams encourages her patients to find work that is gratifying as well as financially rewarding, to experience as much satisfaction in their love relationship as they are providing for their partner, and to recognize and be willing to abandon their "victim" behaviors. She feels women must come to view other women as supports and friends who are as worthwhile as men. The different issues and conflicts modern women bring to therapy are illustrated by case histories and the feminist issues involved in each case are identified in nine chapters dealing with the following topics: (1) the problems women encounter in love relationships, such as loss of identity, failure to fulfill romantic fantasies, and love affairs with father figures; (2) orgasmic difficulties, the problem of traditional masochistic/passive sexual fantasies for the "new woman," and awakening sexuality in a woman who had not realized her sexuality belonged to her rather than to her partner; (3) passivity and lack of commitment, as well as role conflicts and fear of self-assertion in work; (4) various types of mothers — "the potential mother," the dominated, the overidentifying, the angry, and the lesbian mother — and their problems; (5) loneliness and how it can be related to cultural values and women's need to define themselves through their relationships; (6) depression in women in terms of psychological and physiological etiology, and the value of group therapy and helping women to recognize and express hostility and to stop feeling guilty about the parts of themselves they perceive as "bad"; (7) some common transference problems that occur in therapy with women based on their feelings of impotence, passive behavior, need for approval, and need to act the "controlling" mother; (8) several defensive roles women play to ward off anxiety and resist change and how these can be overcome by the therapist and by interactions in group therapy; and (9) phobias in women, the "hysterical woman," sexual fidelity, women's gossip about men, nonsexist child rearing, a feminist therapist working with men, how the women's movement has affected love and sex, the relationship between love and creativity and between sex and anger, and how women are often taught to keep their sexual and angry feelings secret. In a concluding chapter Williams suggests that one of a therapist's most important functions is to help people considering basic changes in themselves anticipate the feelings that will accompany these changes. She warns that women must not be made to feel guilty for choosing to enact traditional roles and asserts that in feminist therapy, as in all other therapies, self-awareness must be the major goal.

386.

Wolfe, Janet L. Rational-emotive therapy as an effective feminist therapy. *Rational Living*, 11(1):2-7, 1976.

In this article Wolfe presents rational-emotive therapy (RET) as a model for a feminist therapy, claiming that no other therapy system better meets the requirements of a truly feminist therapy. RET is helpful to women who have had their consciousness raised, for they can then be assisted in working through their feelings and irrational beliefs so they can begin to function as complete human beings. Wolfe outlines the irrational beliefs most relevant to women's problems and describes how the rational-emotive therapist helps women to become aware of these beliefs and develop new attitudes, feelings, and behavior. "Love slobbism" is presented as women's prime irrational belief, with women focusing on love as their entire existence and feeling worthless without a man. In RET, women's depression and anxiety about lack or loss of love is viewed as resulting from their beliefs about their situation rather than from the situation itself. Women are helped to recognize and question the irrational beliefs that cripple them so that they can begin to rationally deal with their lives. Assertiveness problems are also a major target of RET. They are perceived as directly related to irrational beliefs based on sex-role socialization messages. Much of the time in RET is spent identifying these irrational beliefs, which prevent women from acting assertively. Standard assertiveness-training procedures are also used to teach women the necessary skills. Self-blame, guilt, and the low frustration tolerance that come from women's irrational beliefs about the way things are supposed to be are discussed. RET's method for helping women rechannel the hostility and rage they feel when they recognize their oppression is also presented. Wolfe concludes that RET women's groups have helped more people than regular consciousness-raising groups; she bases this conclusion on reports of women who have done RET and a research study (Wolfe, 1974) that compared a consciousness-raising group with two kinds of assertiveness training groups. RET is identified as an ideal feminist therapy, because it deals with women's problems in a comprehensive way that produces change in attitudes, feelings, and behavior. It teaches women a practical self-help method for challenging their self-defeating thoughts so that they can take control of their own lives. It is noted that the sharing, warmth, and caring recognized as so important in most feminist groups also occurs in RET groups.

Self-Help

387.

Glaser, Kristin. Women's self-help groups as an alternative to therapy. *Psychotherapy: Theory, Research and Practice*, **13(1):77-81, 1976.**

The Central Vermont Women's Mental Health Center, a self-help organization operating since the spring of 1973, is described in this article. Glaser, a participant and the organization's only regular professional trainer, discusses two group interviews she conducted with center members. The center was created by members of a consciousness-raising group in response to dissatisfaction with conventional therapy, mostly with male therapists, and a desire to deal with their problems themselves. Participants are mainly non-native Vermonters who are in their twenties or early thirties and who are from middle-class backgrounds. The self-help model now used involves training in both counselor and client roles followed by participation in a mutual therapeutic exchange for everyone who comes to the center. People are first taught "listening" to others and then "focusing" or listening to themselves. A session begins with informal conversation and is followed by some kind of training or general discussion. The women are then separated into groups of three or four in order to counsel. These groups usually have a contract to meet for several weeks. In the session one person listens, another focuses and works on her problem, and the third person observes. All women are made to feel welcome and are treated warmly and nonjudgmentally. In order to identify reasons for coming to the center, perceptions of the group, gains women felt they had made, and differences or similarities between self-help and psychotherapy, group interviews were conducted with seven women in May 1974 and with nine women in January 1975. Four women participated in both interviews. The material is summarized, with the most common responses emphasized. An abbreviated listing of the actual responses is included. The groups were found to have more similarities than differences. In May the group was particularly interested in the positive differences between self-help and therapy, but in January most of the women came for therapeutic reasons. Responding to the question of how self-help differs from regular psychotherapy, the women stressed that self-help provided the opportunity for more healthy and growth-directed change and can be especially important for women who have been traditionally cast in passive roles. The women voiced concern about the "one up/one down" politics of the therapeutic relationship and described getting more for oneself as the main positive aspect of therapy. The women felt that the self-help approach encourages responsibility for one's own therapeutic work; they like this responsibility and believe that they are making changes in their lives. When asked why self-help is particularly important for women, the participants responded that it moves women out of the more passive roles, particularly the role of dependence on the parental figure "shrink"; that it teaches women to experience and to accept themselves; and that one can learn self-respect when another woman is a respectful listener. The women expressed positive feelings about getting together with other women to learn therapeutic skills, to work on their own problems, and to be helpful to others. Although participants felt good about the group, dissatisfactions were also voiced. The author points out that the principles and therapeutic skills of self-help are not limited to any one ideological framework, that the organization and the ideas can be applicable to the needs of any women who want to be involved. Suggestions are made for future research.

388.

Kaplan, Mildred Fine; Lazarus, Esther; and Saidel, Barbara H. A self-help telephone service for women. ***Social Work*****, 21(6):519-520, 1976.**

Two social workers and a psychologist describe the free peer counseling service they created for women, Women-In-Self-Help (WISH). This is a self-help organization, staffed by volunteers — a group of women who share a common interest and who join together to meet their own needs among peers. The service's objective is to break through the isolation that commonly affects women within the traditional nuclear family and to help the woman deal with her everyday needs and problems. The organization of the service is described, along with its peer level training procedures. The volunteer training emphasizes the development of empathic and objective listening skills and the acquisition of sufficient self-knowledge for the volunteer to hear objectively what a caller says and thus leave the responsibility for self-determination to her. Additionally, the volunteer is encouraged to explore her own experience as an aid to being responsive to the other woman's situation. The WISH service is different from the expert-client model used in professional counseling in that it focuses on the commonality of experience between caller and listener. Describing the service's first 228 calls, the authors report a fairly even division among requests for information, referral, or peer counseling. The women represented all economic, social, racial, and religious groups as well as a broad age range and a variety of lifestyles and levels of functioning. Calls requiring substantive peer counseling involved a variety of problems that reflected age-appropriate life crises for women. A common theme to all the calls was a reaching out to do something more productive both for and with oneself. The underlying emotions that blocked the women from taking direct positive action on their own behalf included feelings of inadequacy, anxiety, and conflict as well as a lack of confidence. The counselor's objective, understanding, and accepting response to the feelings a woman expressed about herself and her situation created an impetus for the woman to overcome her inhibiting negative feelings. This peer counseling contact often results in directing a caller to a resource other than the one she may have requested initially. The authors conclude with an analysis of WISH's first 3 months of operation, a discussion of implications for future delivery of services, and the opinion that WISH has reached women who would not otherwise have been reached.

389.

Silverman, Phyllis Rolfe. The widow as caregiver in a program of preventive intervention with other widows. ***Mental Hygiene*, 54(4): 540-547, 1970.**

Based on 3 years' experience with the Widow-to-Widow program in Massachusetts, Silverman advocates the establishment of a self-help organization for widows. Five widows who had successfully completed their period of bereavement functioned as counselors, or aides, and reached out to 400 widows in this preventive intervention program for new widows under age 60. The new widow was approached with a letter of introduction on stationery bearing the names of the three religious groups that were sponsoring the program. In the letter, the aide relates that she is a widow and indicates a specific day and time when she will visit. The aide's home phone number is given if the widow prefers that the aide not visit. Silverman relates that for those who became involved in the program, the shared experience of widowhood made the trust and involvement easier to accomplish. The new widow stops feeling so isolated and stigmatized and is free to talk and admit to fears and grief. The aides consider the first step to be the widow's ceasing to see herself as married and coming to think of herself as widowed. They identify the following three themes in this process and offer assistance with each stage: (1) learning to make decisions independently; (2) learning to be alone; and (3) learning to make new friends and to be out with people. Regarding decision making, the aid is initially willing to give direct advice and dependency is acceptable, but later the widow is encouraged to act independently. Most of the women reached in the program were able to make this transition to independent action, although a small group clung to their old ways and seemed to be searching for a replacement for their husbands to make their decisions. The aid helps with the widow's loneliness by being available, if only by telephone, to talk and to empathize with this problem which the aide is also experiencing. Finally, the aides help the widows find other groups of "single" people with whom they might share common interests and reach out to other widows in their immediate neighborhood who have refused to see the aide or who are so physically disabled that they cannot leave home. This latter involvement gives the widow a sense of worth and independence and also provides continuity to the program. A self-help organization for widows is identified as similar in function to a program such as Alcoholics Anonymous, for nonprofessional workers with shared experiences are used. Silverman identifies the goal for a self-help program to be a partnership between the independent self-help groups and a formal agency whose expertise is available if needed.

390.

Silverman, Phyllis R., and Cooperband, Adele. On widowhood: Mutual help and the elderly widow. ***Journal of Geriatric Psychiatry*, 8(1):9-27, 1975.**

Concern in this paper is focused on the elderly widow. The authors attempted to learn whether widow-to-widow services work differently with the elderly widow in an agency setting. The work reported is an outgrowth of the senior author's original widow-to-widow experiment. Before discussing the study itself, the author proposes mutual help as an alternative mode of helping that involves the positive qualities of family and community. She identifies another widow who has coped and accommodated as the best caregiver. Silverman discusses the issues in bereavement and widowhood and criticizes the professional mental health community for defining as problems the normal dilemmas of living. She goes on to elaborate upon and define the functions provided by mutual help groups. The widowed caregiver in this study, Adele Cooperband, as an employee of a Jewish Community Center, worked alone reaching out to the widows. For the purposes of the paper, Silverman interviewed Cooperband in order to obtain as much information as Cooperband could recall on what she had done. Involved in the original program, Cooperband has family members in this community, is over 65, speaks Yiddish, and lives nearby to and is known to some of the widows and their families. In this primarily working class community, a mass emigration of the Jews had occurred and crime rates had increased, making it dangerous to go out to shop or to the synagogue. Followup was possible on 93 of the 99 Jewish women over age 50 who had been widowed during the last 18 months. Cooperband, identifying herself as a widow, wrote to each new widow. She indicated that she would like to visit and see if she could be of help. Fifty of the 93 widows agreed to see her. The women who refused help were more likely to be working, in good health, in more stable living situations, with adequate friendships, and having manageable reactions to their husbands' deaths. Among the women who accepted help, there were indications of the important part dangers played in their daily lives. The husbands of these women had been their companions and helpers and had made them feel safer. Their need for help seemed related to their inability to maintain an active and involved life. They, just as younger widows, wanted the caregiver to help make their lives viable again. An example of a communication between a widow and the caregiver is included. In a discussion of how the needs of the different widows were met, examples are given of a widow who did not require any ongoing relationship, widows who needed more sustained contact, the help offered to one widow whom the caregiver considered to be neurotic, and the effort made to involve a large group of widows with the multiservice community center. Other examples demonstrate the value of reaching out to widows. Silverman points out that in the helping encounters described, feelings are accepted as existing and appropriate, but focus is on concrete and specific problems. The goal in helping these women was to keep them involved and connected to the world and to other people so they could continue living.

She concludes that mutual help is very applicable to the elderly and that it can work in an agency setting. The need of the elderly widow for someone to talk to, a peer, is identified, and Silverman suggests that a mutual help effort provides the opportunity for meeting this need.

391.

Silverman, Phyllis R.; MacKenzie, Dorothy; Pettipas, Mary; and Wilson, Elizabeth, eds. ***Helping Each Other in Widowhood.*** **New York: Health Sciences Publishing Corp., 1974. 212 pp.**

This book combines the proceedings of two workshops held in 1971 for the purpose of developing understanding and the necessary skills to initiate new programs to aid widowed people. The first workshop was attended by 100 widows and widowers who shared their experiences and work efforts on the development of new programs. Emphasis was on the need to reach out to the newly widowed. The second workshop was attended by professionals who serve the widowed and was designed to make them more sensitive to the problems of widowhood and more aware of alternative modes of helping. Focus, again, was on the development of widow-to-widow programs. Part I of the book deals specifically with the original Widow-to-Widow Program. In the first chapter Phyllis Silverman describes the idea of an outreach program and how it was developed into a mutual aid effort in which widows helped each other. The second chapter includes contributions by three widows who worked as aides in the original Widow-to-Widow Program. They describe what it is like to offer support to new widows and give examples of the problems they encountered. The next three chapters are devoted to a sociological perspective on the program, a description of the inception of a hotline for widows, and the experience of one hotline worker followed by a sociologist's report on what was learned from this Widowed Service Line. In Part II, "How to Help Each Other," information from the workshops attended by widows and widowers is provided. This five-chapter section presents an outline for the establishment of a program for the widowed, the experiences of representatives from each of the widows' programs participating in the workshop, a summary of the content of the five workshops, Silverman's discussion of her role as a professional working with a mutual help program and her warning against allowing professionals to take control, and a description of an orientation program for new volunteers which emphasizes helping them apply their unique expertise rather than concentrating on training in a professional sense. The objective of Part III, "Death, Grief and Bereavement: The Professional Perspective," is to present the problems and attitudes of the people whose work is to serve the dying and bereaved. This section provides background information so that the people who receive help, and traditionally must accept it without criticism, can have some basis for initiating a dialogue about their real needs with those who wish to help them. The remaining four chapters are presentations by a sociologist, a physician, a rabbi, and a funeral director that relate to this area of concern. Phyllis Silverman provides an epilogue concerning the problems of widowhood that the widowed members of the workshop shared with each other.

392.

Tennov, Dorothy, and Payne, Helen. Setting up a self-help counseling (C_1C_2) project: Suggestions and guidelines. Copyright © 1974, Dorothy Tennov. 8 pp.

In a question-and-answer format, suggestions and guidelines are provided for the establishment of a self-help (C_1C_2) project. The objective of the self-help project, in which C_1 is the person focused on and C_2 is the listener, is to provide peer support and "counseling" on a one-to-one basis. The projects are based on the belief that all people who have problems to deal with and decisions to make find it helpful to be listened to attentively with interpretation, analysis, or fear of challenge or interruption. No distinctions are made between the C_1 and the C_2 — a person may be the listener one day and the person focused on the next. The authors indicate that the C_2 role is not that of psychotherapist, and there are specific guidelines for the listener which include the following: (1) to listen attentively and respectfully and to help the C_1 decide what she wants to do without giving advice; (2) to be honest without feeling obligated to express all one's reactions and feelings, particularly if they are negative or critical; (3) to respect the C_1 and accept her at face value, hearing what she says and assuming that she makes sense; (4) to exert no pressure and to be careful that questions of clarification never sound like criticism; (5) to recognize that listening in itself has much value and to remember that it is not necessary to do anything; and (6) to give freely any information that may be useful to C_1 or to try to help her obtain the needed information. Additionally, both the listener and the person focused on are aware that they are peers and that their roles are interchangeable — "to want to talk about one's problems is not sick and to listen to someone talk is not psychotherapy." Copies of guidelines are made available, and guidelines are demonstrated in group training sessions. Although the guidelines for both C_1C_2 and consciousness raising are similar in their fundamental emphasis on respectful attention and freedom from challenge, criticism, and interpretation, there is a one-to-one relationship in the self-help project in which the C_1 has the opportunity to focus extensively on the minute details of her situation in contrast to the consciousness-raising group's concentration on individual problems only as they relate to understanding society. The authors discuss the specifics of establishing self-help projects on an informal or community-wide basis, assigning a caller to a particular C_2, identifying the different places that have been used for sessions, pointing out alternatives for financing the project along with the expenses involved in its operation, compensating the C_2, and using professional consultation for emergency situations.

Other

393.

Berman, Marilyn R.; Gelso, Charles J.; Greenfeig, Beverly Rosenfeld, and Hirsch, Rosalyn. The efficacy of supportive learning environments for returning women: An empirical evaluation. ***Journal of Counseling Psychology*****, 24(4):324-331, 1977.**

There have been few outcome assessments of groups assigned to help women make changes in areas of vocational decision making, learning attitudes, attitudes toward women, and receptivity to new information. To remedy this lack, the authors investigated two such groups, one at the University of Maryland and one at a community service agency. They sought to determine if changes, which would influence women's lifestyles, could be brought about by the provision of a supportive learning environment instead of through traditional individual or group counseling. University subjects were 36 women who were returning to or entering the university after a lapse in their educations; there were 12 waiting-list controls. The women ranged in age from 23 to 60 and, typically, were married, mothers, and the wives of semiprofessional men. Eighteen subjects met once a week for 3 hours for a 5-week summer session, and 18 subjects and 10 controls met once a week for 2 hours for 15 weeks in the fall semester. The sessions included guest discussion leaders, and subjects were required to complete four projects designed to encourage active goal-related information gathering. Outcome measures assessed vocational decision-making attitudes, learning attitudes, attitudes toward women, and receptivity to new information. The community setting study involved 55 experimental subjects and 11 controls, aged 23-55, who, typically, were mothers and were married to professional or semiprofessional men. The women were exploring new vocational and psychological goals for the first time. They met once weekly for 8 weeks in large group didactic and small group discussion sessions. Information was presented about vocational planning, employment trends, educational opportunities, decision making, assertiveness training, and personal awareness training. In the small group sessions there was an opportunity for self-analysis, risk taking and sharing of personal-emotional concerns. Outcome measures were vocational decision making, self-concept, and attitude toward women. Only 7 control and 21 experimental community subjects completed the pretest, posttest, and delayed posttest control. Comparison of the university experimental versus control subjects indicated significantly higher scores on the Vocational Decision Making Checklist, although there were no significant differences on Attitudes Toward Women, Self-Concept as a Learner, or Dogmatism Scales. Community subjects showed significant experimental versus control group differences on two posttests for the Index of Adjustment and Values in the direction of improved self-concept. Their differences on the Vocational Scale approached significance at second posttest ($p = .14$). Although pre- to posttest experimental group changes on Attitudes Toward Women were significant for community subjects, this finding was not supported by between-subject comparisons and may have resulted from selection biases inherent in high dropout rates and from the relatively high initial scores. Dogmatism was not found to be a significant factor. These results indicate that nontraditional techniques may be effective in helping women to change undesired behaviors and that lifestyle changes can be effectively aided in supportive education programs. The authors suggest the need for more research to determine factors related to success in such groups.

394.

Byrne, Beverly. ***The Love Seekers.*** **Westminster, Md.: The Newman Press, 1967. 155 pp.**

The author's personal experience and case histories while director of the Lataste House, a halfway house for released women prisoners in the Boston area, are recounted. The concept of the "Caesar's wife syndrome" — or the public's inability to deal with women who have "betrayed" their sex by requiring imprisonment — is presented. Such behavior has been regarded as a slap at all the cherished feminine virtues. Byrne notes that 90 percent of the women imprisoned are guilty of crimes against the public order — adultery, drunkenness, prostitution, and abortion — and not of crimes against person or property. These can be termed acts of weakness rather than violence. The prison system proves unable to meet their needs for psychotherapy and social rehabilitation. Women came to Lataste House from the surrounding prisons. The house attempted to provide a supportive family environment where the women could live from 3 weeks to a year. The women were assisted in finding jobs, provided with companionship, and generally eased into freedom after living under strict prison control. Problems that arose were related to the addictions of many of the women and the institutionalized mentality that they had acquired. The latter manifested itself in the form of extreme inertia alternating with impulsive action. Byrne stresses that halfway houses must be integral parts of their communities in order to succeed. The women need outside social contacts, for they have an overwhelming need for love as well as employment. Lataste House closed after 18 months in October 1965 largely due to pressures from the community in which it was located.

395.

Gluckstern, Norma B. Beyond therapy: Personal and institutional change. In: Rawlings, Edna I., and Carter, Dianne K., eds. *Psychotherapy for Women: Treatment Toward Equality*. Springfield, Ill.: Charles C Thomas, Publisher, 1977. pp. 429-444.

Gluckstern presents the idea that involvement in social and political action to deal with institutional problems can work therapeutically to help individuals free themselves from old patterns of behavior. A diagram is provided that conceptualizes how process and goals intermix to bring about change in both individuals and institutions. Gluckstern describes her own experience in working with a group of women to create a women's center on a university campus, revealing how the group developed and how individual and institutional growth were fostered in the process. A figure illustrates the evolution of the women's organization, which approximated the Biddles' (Biddle and Biddle, 1965) six stages of community action. Gluckstern reports that the difficulties experienced in setting up the women's center reflected the very institutional and personal problems they were trying to address. The women working on this project had to reevaluate their traditional orientations. The conflict this created brought about changes in their personal values and lives. They had to overcome the fear of action and risk taking that was part of their socialization. In so doing, they all gained greater self-confidence and began to take each other more seriously. The group provided support, pressure, and an impetus to act. The center they created helps women in some of these same ways. The political action group is seen as moving from common political goals to a consideration of personal issues. Gluckstern indicates that such groups provide a safe arena for women to try out new behaviors. The differences between action groups and consciousness-raising groups are discussed. Working in action groups helps women to differentiate between internal and external restraints. A political consciousness emerges that contradicts women's habit of blaming themselves for everything. The author describes how working in a political or social action group opens up new alternatives and options for women by making them aware of their competencies and giving them new role models. A diagram illustrates this process in which social action changes women's lives and the institutions that affect them. The danger of creating new dependencies as opposed to healthy interdependency is discussed as is the issue of making alliances between women of all classes and racial backgrounds. Gluckstern concludes by recounting how her political involvement and decision to become a counselor/activist rather than a traditional counselor helped her to grow — she was made to face a tendency toward passivity and inaction that her counselor training fostered. Gluckstern suggests that political and social action have tremendous therapeutic potential.

396.

Guzell, Marie Celeste. Problems of personal change in women's studies courses. In: Rawlings, Edna I., and Carter, Dianne K., eds. *Psychotherapy for Women: Treatment Toward Equality.* Springfield, Ill.: Charles C Thomas, Publisher, 1977. pp. 310-327.

Based on her experience teaching women's studies courses, Guzell asserts that, like therapy, these courses have the potential of opening people to change. Women's studies courses differ from other academic courses in their dedication to feminist goals of equality and human freedom, in the volatile nature of the subject matter explored, and in the expectations of the students who register for them. Although in some ways they resemble consciousness-raising groups, they differ greatly in their structure and process. Guzell notes that students from an environment with strong support for feminism are more likely to make extensive positive personality changes while students from conservative backgrounds are more likely to experience unresolved conflicts. She discusses both the positive and negative aspects of the changes that can occur in women as a result of women's studies courses. Women realize that their problems are not unique but are shared by other women, their alienation is reduced, and they develop a more objective and realistic approach to career, marriage, education, and motherhood. However, as there is insufficient time for them to reach the final stages of feminist consciousness, many women report discomfort, anxiety, and a need for continuing interaction with a women's studies group. Additionally, Guzell provides a detailed report of two empirical studies that deal with the effects of women's studies groups. She concludes that the seed for personality change can be planted in women's studies courses and that the instructor has the responsibility of being a change agent. Twelve recommendations for increasing the therapeutic potentials of women's studies courses are offered: (1) provide students with opportunities to express themselves about personal but relevant matters; (2) give students time to digest explosive material and intersperse disturbing stories about sexism with positive ones about male-female interactions; (3) avoid excessive overgeneralizing about men; (4) discuss the subject of men's roles in class and societal oppression at the beginning of the course in order to avoid guilt and anger in male students; (5) use the small discussion group as an effective way to discharge anger generated by class discussions or personal transactions; (6) use social action as a means of reducing helplessness and anger women students may be feeling toward men; (7) discourage men from dominating women's studies classes as this limits possibilities for therapeutic goals such as self-assertion; (8) be able as instructors to refer students for psychological treatment or legal services as needed; (9) prepare students in advance for the uncertainties they will experience when they question traditional sex roles; (10) give androgyny tests as a way of allaying fears about loss of femininity; (1) directly confront the differences between sex roles and sexuality in order to help students face their fear that giving up stereotypical notions of masculinity and femininity will lead to loss of their sexuality; and (12) provide a short reading list that will promote understanding between women students and their male friends.

397.

Raffini, Mary. A feminist alternative: The Elizabeth Stone House. ***RT: A Journal of Radical Therapy*, 4(6):12-15, 1975.**

Mary Raffini, in the first part of this article, "Concept and Creation of the Elizabeth Stone House," tells of her struggles to establish this alternative — a residential therapeutic community for women in the Boston area. Raffini began working toward her goal in 1973 after release from her second psychiatric commitment. Her objective was to find an alternative to mental hospitals that could also serve as a center where women could "work out the political and theoretical problems of what a 'feminist therapeutic house' meant." Elizabeth Stone House opened in July as a project of the Cambridge

Women's Center. The top two floors of the house, with eight bedrooms, are used for the therapeutic community and the lower floors are primarily used for a residential crisis center and therapy referral center. Equal responsibility for each resident was decided on as a contract for living in the house. The second part of the article is an interview with Raffini by *RT* journal writers that took place in March 1975. Raffini indicates in this interview that the resident composition of the house is in a transitional stage. She points out the difficulties encountered by a therapeutic community that operates on a no staff/patient model. The residents function as a collective with weekly meetings to discuss problems. Originally, counseling was envisioned as informal peer counseling on the basis of residents' need. As this arrangement was not effective, separate weekly meetings were held to discuss feelings. Finally, it was felt necessary to bring in a facilitator from the Women's Center for these sessions. Elizabeth Stone House is distinguished from a halfway house by the fact that a no staff/patient model is used and that each person has to take a much higher degree of responsibility and initiative and must be more highly skilled in communicating. The interview then shifts to the differences between the long-term program and the refuge center, and planning for the refuge, or crisis center, is discussed. It is to be oriented toward short-term crisis intervention, designed primarily to allow women to avoid hospitalization. The emphasis will be on peer counseling, and the staff members are to be people with considerable intervention experience. The staff training program for the crisis center is discussed as is the relationship of Elizabeth Stone House to the surrounding medical establishment. Raffini concludes the interview by requesting feedback from people who are trying to do similar work.

Self-Help Reading for Women

398.

A guide to consciousness-raising. ***Ms.*****, 1(1):18,22,23, 1972.**

This article provides a practical guide to the consciousness-raising or rap group that forms "the heart and soul of the Women's Movement." The consciousness-raising group gives women a chance to end their isolation and come to realize that others share their problems. Women find out who they are, as opposed to who they were conditioned to be, and come to understand the political relationship of women to society. Practical ways of changing their lives are learned. Concerns about how groups are formed, where and how they meet, and the actual procedure and process are discussed. Members must be committed to changing their lives, and there must be trust in confidentiality because of the intimacy involved. The groups are leaderless, and it is the responsibility of each member to assure that everyone participates fully. Talk in a consciousness-raising group is expected to be personal, subjective, and specific. Each member is given complete attention when she speaks, and no interruptions are to be made except for the purpose of clarification. A woman's personal testimony is not judged nor is advice offered. Subjects discussed may emerge naturally from the group, but the importance of not spending too much time on daily functional problems, considered to be the symptoms rather than the disease, is emphasized. It is noted that most groups find discussions that initially focus on childhood and family experiences work best. A list is provided of the kinds of questions consciousness-raising groups might explore. After personal testimony is given, the entire group needs to discuss the common elements in their experience. The end of each session should be devoted to summing up. It is concluded that as the group grows and changes, the individuals will grow and change too.

399.

Barbach, Lonnie Garfield. ***For Yourself: The Fulfillment of Female Sexuality.*** **New York: Anchor Press/Doubleday, 1976. 218 pp.**

This self-help book directed to women provides the physiological information, the psychological support, and the exercises to help a woman learn more about her body and its needs, realize her own sexual potential, and overcome sexual difficulty, specifically the problem of lack of orgasms. The book is based on information gained from an all-women's preorgasmic group treatment program which the author describes. In addition to basic information about female sexuality and stories from women in the groups, much of the book's material is aimed at helping a woman understand her own body and sexual responses. Discussing sex and orgasm, Barbach indicates that orgasm is a natural and healthy process that each woman is entitled to enjoy in her own individual way. She identifies some of the sources of women's sexual confusion, suggesting that knowing how she got to her current situation may help a woman realize that she is not alone in her confusion. Advising readers that there are solutions for the binds of being a spectator at one's own lovemaking, faking orgasms, participating in sex for the partner's sake, and avoiding sexually frustrating situations, Barbach recommends that a woman start by discussing the problem with her partner as soon as she feels ready. In taking her first steps toward change, Barbach focuses on the need for a woman to open up her feelings about her sexual past, to begin feeling she deserves more for herself, and to get back in touch with her body. Exercises for accomplishing the latter are provided. After a brief description of the female anatomy and the sexual response cycle, the reader is instructed to examine her body and genitals completely and carefully. Pointing out that sexual arousal consists of more than just physical genital stimulation, Barbach elaborates on the psychological aspects of reaching orgasm. Masturbation is identified as one of the best ways to learn about one's sexual responses. Once a woman learns about how she sexually responds through stimulating herself, she will be able to shift her body movement during sexual intercourse to achieve more pleasure or teach her partner how to stimulate her in the way that will most likely bring her sexual pleasure and eventually orgasm. Exercises are provided to help the woman reach orgasm through masturbation as well as to help her develop and extend her sexuality with self-stimulation so that she can transfer her new knowledge to a partner relationship. After becoming orgasmic through self-stimulation, a woman's next step is to integrate the process into a sexual relationship with a partner. Partner exercises are provided and suggestions are made concerning the significant issues that will need to be confronted if the women is to become orgasmic with a partner. Suggestions for sexual expansion are also included. In the final chapters Barbach deals with sex during pregnancy and menopause, sex for the aging woman, responsibility for one's body, and the concept of personal liberation. She identifies sexual liberation as a beginning to personal liberation.

400.

Boston Women's Health Book Collective. *Our Bodies, Ourselves: A Book By and For Women, 2d ed.* **New York: Simon and Shuster, 1976. 383 pp.**

This book, written by women for women, is designed to help women understand their own bodies and feelings. Pragmatic factual information is presented in a direct manner, and definitions of specialized medical terms are included so that women will be better able to maintain control over any treatment they require from physicians. The factual information is augmented with personal testimony of women whose experiences are relevant to the topics under discussion. The book's comprehensive chapters are illustrated and conclude with a recommended reading list. The authors explain how the preparation of this book evolved from their rediscovery (as members of a feminist collective) of themselves as active independent people. In a chapter devoted to the anatomy and physiology of reproduction, the authors discuss the alienation women often feel from their own bodies, present detailed factual information on the structure and function of women's sexual and reproductive organs, and provide diagrams for a recommended self-examination. Sexuality is dealt with in a comprehensive way, drawing upon the authors' experiences and the research of Masters and Johnson. Feelings about various aspects of sexuality are shared, a personal and somewhat clinical discussion of female sexual response is provided, and an appendix includes information on a variety of subjects such as problems with sex and suggestions for organizing a women's sexual discussion group. Focus moves to interpersonal relationships that are primarily shaped by sexual feelings; attention is given to adolescent sexual feelings and involvements and the experiences of adult women in a variety of relationships and lifestyles. Subsequent chapters deal with the lesbian experience; information about keeping oneself healthy through exercise, nutrition, and health habits; medical terms and examination procedures, and techniques for pelvic self-examinations, as well as traditional and alternative treatments for many common medical problems; rape; self-defense; and veneral disease. In the chapter on birth control the authors discuss the social and political aspects of contraception and provide detailed information on the various methods available. The subject of abortion is dealt with in this same comprehensive approach; information is provided on how to find the best abortion facility, and abortion procedures are described. A chapter is devoted to the decision of whether or not to become a parent, and a realistic appraisal of what happens when people have children is offered. The following three chapters comprise a "Childbearing Unit" for the purpose of affirming childbearing as a dignified creative act and educating women both physically and psychologically for pregnancy, childbirth, and the postpartum period. Following a chapter on menopause, the authors present an overall picture of the relationship between women and the health care system. They give a political interpretation of why health care in America is so terrible, propose an alternative theory of disease prevention, express concern about helping women choose and use medical care in an active way, and, finally, include models for organizing and developing alternatives to the current system.

401.

Cleveland Women's Counseling. ***Guidelines for Women Seeking Psychotherapy.*** **2d ed. Cleveland Women's Counseling, Box 18472, Cleveland, Ohio 44118. 11 pp.**

In this pamphlet prepared by Cleveland Women's Counseling, guidelines for women seeking therapy are provided. Initially, the authors point out that millions of women are experiencing similar problems in their efforts to adjust to contradictory and unfulfilling socially prescribed roles and patterns. Although therapy can help women to cope with resultant confusion and identity problems and to make outward changes necessary for growth, the authors warn that one should not be oversold on its value. They point out that studies have shown that some individuals are not helped by therapy and that for some it is actually harmful. The authors identify further negative aspects of therapy, indicating that therapists incorporate the prevailing social attitudes toward women into their thinking. They suggest that a woman who wants therapy neither give up her independence and values nor place her total self in the hands of a therapist; she should try to clarify the issues on which she wants to focus and, additionally, join a consciousness-raising group and a women's movement talking (action) group. According to the authors, various kinds of therapists can help women; quality in therapists differs considerably according to the individual and is not dependent on a particular professional degree. Clinical psychologists, paraprofessionals, psychoanalysts, psychiatrists, and students as therapists are described and differentiated. The need to interview a therapist before entering therapy and to evaluate this interview is identified. Before a woman determines the appropriateness of a therapist, the authors suggest that a woman question the therapist about matters relevant to her therapy, noting that this also serves to establish a tone of equality in the relationship. Several questions are offered as a guide, such as what are the therapist's ideas concerning a mentally healthy woman and the source of these ideas; what does the actual therapeutic interview feel like and how responsive or interactive was the therapist; and does the therapist have sexual relationships with other clients. They suggest that a woman trust her feelings in evaluating this interview, indicating that the interview is a preview of what working with this therapist will be like. Again, they provide questions that may be helpful in evaluating the interview. Other issues concerning therapy are discussed — fees, handling grievances during the course of therapy, confidentiality, commitment to a mental institution, medication — and a brief bibliography focusing on women and psychology is included.

402.

Krakauer, Alice. A good therapist is hard to find. *Ms.*, 1(4):33-35, 1972.

On the basis of her experience as a graduate student in clinical psychology, Krakauer reports how unhelpful psychological theory can be for women. Accepted theory led her to believe she was "psychosexually confused" — she felt competent, i.e., masculine, at work but childlike and feminine at home with her male companion. She notes that therapists who believe a woman should be "feminine," as prescribed by society's sex-role stereotypes, will limit a woman's perception of her options, obscure her possibilities for change, and increase her hopelessness. Krakauer warns against therapists who claim politics has no place in their therapy, suggesting they are often unaware of how intrusive their politics are. She points out that the selection and training of people to be therapists has little to do with developing the kinds of understanding that make for good therapy. As with most professions, therapists must prove their grasp of conventional thinking. Their training isolates them from the realities of poverty, racism, and sexism that are relevant to most people. To keep their privileges, professionals conform in their thinking and behavior. Due to their own fears, they may discourage those qualities in their patients that are necessary for growth and change. Krakauer concludes that professional credentials are no guarantee that a therapist has the ability to help someone. Although referral services now exist for women, she indicates that each woman must decide for herself who can help her in her liberation. The following suggestions to help in choosing a therapist are offered: (1) try to get recommendations for therapists from people who have changed in a way you would like to; (2) if possible, have consultations with at least two therapists before selecting one; (3) question therapists about their theoretical stance and be wary of those who are so unaware of their own psychology that they claim to treat men and women exactly the same; (4) although women are apt to be more aware of the problems of women and to empathize, a "nonmacho" male therapist may be able to help — but consider a consciousness-raising group as a way to monitor for sexism in therapy with a professional of either sex; (5) examine the issue of fees; (6) look for nondefensiveness and unpretentiousness in the way the therapist deals with your questions; and (7) be aware that regardless of politics, a therapist who implies a person should be a certain way will make it more difficult for a woman to discover who she is.

403.

Kushner, Rose. *Breast Cancer: A Personal History and an Investigative Report.* New York and London: Harcourt Brace Jovanovich, 1975. 400 pp.

This book combines the author's personal experience with information gleaned from the literature on breast cancer and from experts in the field in both the United States and Europe. The purpose is to provide women with a reference work that tells them all they should know about breast cancer and what they have a right to expect in treatment. Kushner begins by relating her own experience with breast cancer and her research to find the kind of treatment she wanted and protect herself from treatment she considered unsound. She provides a factual explanation of the general disease of cancer and of breast cancer specifically. How the breast functions and its complexity are discussed, and an anatomical description of its cells and how they are related to the lymphatic system is provided. Specific kinds of breast cancer are described, and their frequency and chances for cure are included. In a chapter entitled

"History, Myths and Quackery," Kushner notes how little progress has been made in the treatment and cure rates of cancer and suggests that physicians who know little about cancer, but insist on treating it, should be considered quacks. Another chapter deals with the epidemiology of breast cancer and provides information concerning statistical charts, graphs, and tables and the various ways they are compiled. A scorecard is presented so women can determine their own risk category and what precautions they should take. Another chapter is devoted to possible causes of cancer that researchers have posited. The Food and Drug Administration is indicted for its failure to warn women about the relationship between birth control pills and breast cancer despite research showing that estrogen in oral contraceptives, while perhaps not directly causing cancer, clearly nourishes it. In a chapter focusing on early detection, Kushner points out that 95 percent of all early breast cancers are found by women rather than physicians, and she stresses how important breast self-examination is in saving lives. A diagram and detailed instructions are given for self-examination along with common warning signals. Other early detection techniques now in use, such as mammography and thermography, are also discussed, as is a model for vital followup examinations to detect any recurrence of cancer after a mastectomy. Kushner also deals with the controversy over the American practice of doing a mastectomy immediately after a biopsy on the basis of a frozen section and the European practice of taking some time after a biopsy to do staging and determine how far the cancer has spread before proceeding with major surgery. A strong defense of the superiority of the European approach is presented. Describing alternative surgical procedures, Kushner maintains that women must have the right to make their own decisions on the treatment they want based on all the available facts. Two chapters deal with discussions of the physical and psychological symptoms that follow surgery. Another two chapters are concerned with chemotherapy, radiotherapy, and immunotherapy—treatments that may be used when mastectomy fails to eliminate the spread of cancer. Kushner points out the major part male chauvinism plays in all aspects of breast cancer, from the media's emphasis on breasts for sex appeal to how money is allocated in cancer research. The final chapters deal with the current status of breast cancer treatment and its prospects for the future. Suggestions are made for more sensitive treatment of cancer victims.

404.

Phelps, Stanlee, and Austin, Nancy. *The Assertive Woman.* Fredericksburg, Va.: Impact, 1975. 177 pp.

This self-help book was designed to help women develop assertive skills. It includes many questionnaires and exercises that women can use to evaluate their present degree of assertiveness and learn how to behave more assertively. Passive, aggressive, indirect aggressive, and assertive behaviors are defined and differentiated. Life situations and the responses they elicit from each behavior type are described so that readers can determine what kind of behavior they manifest. Material is provided to help women develop assertive body images, and detailed instructions are given for deep muscle relaxation and for developing hierarchies to overcome the anxiety that changing behavior often engenders. The authors note the importance of reducing anxiety and learning to relax as a prerequisite for doing all the other exercises they present in this book. A chapter is devoted to helping readers come to know themselves better and develop an assertive attitude, and techniques that women can use on their own are suggested. Guidelines from basic learning principles are provided so that assertive behavior can be acquired in a structured way that promotes success. The importance of understanding how previously learned sex-stereotyped attitudes and behaviors affect attempts at assertiveness is stressed. The authors include a series of exercises for developing assertive attitudes and a feeling of personal power, emphasizing the importance of initiating action. Another chapter focuses on helping women deal assertively with compliments, criticism, and rejection as both givers and receivers; action exercises for developing these skills are provided. Material to help women learn to say "no" without feeling guilty, and methods for recognizing and dealing with manipulation are offered. The authors also address the concept of being sensually assertive, and they recommend reading material for those who want how-to information on sexuality. Focusing on anger, the authors give examples of various indirect ways anger is expressed as well as action exercises for learning to assertively express anger. Other chapters are devoted to discussions of how humor can be used assertively, dealing with children assertively, and the importance of women helping each other learn to become assertive individuals. The authors conclude by reassuring women that while new assertive behavior may be initially disruptive, it will prove beneficial in the long run. They discuss some ways in which assertive women are changing social institutions and make suggestions on how readers can act as "agents of change."

405.

TenElshof, Annette, and Searle, S. Elizabeth. Developing a women's center. ***Journal of the National Association of Women Deans and Counselors*, 37(4):173-178, 1974.**

The authors first establish the need for women's centers on college campuses to help women prepare for societal roles as self-actualizing individuals and then provide practical information for setting up and integrating such centers into the academic community. Eleven objectives for the center are identified, including raising women's self-esteem, providing counselors who are aware of women's special problems, and serving as an advocate for women students in the university community. Suggestions are made for funding. The authors discuss the organization of the women's center, indicating that a cooperative model is often used because it allows women to learn the decision-making process. The space needs of a center are also briefly mentioned. Programs for the women's center that satisfy its objectives are discussed in some detail. Under the heading "Counseling," the authors recommend that the center offer consciousness-raising and awareness groups as well as programs dealing with life-planning, health, financial, legal, and personal problems. Nonsexist career counseling is also identified as an important service to offer. A resource library with information related to women's concerns is considered a vital part of a center. Topical programs that deal with subjects such as abortion and legal rights are discussed as are skills programs focusing on such things as self-defense, basic carpentry, and writing a vita. The authors suggest that a program in which students could meet successful women professionals is a way of providing positive role models. They discuss the need for leadership training and present a variety of other programs a women's center might offer.

406.

Wolfe, Janet L. "How to Be Sexually Assertive." Institute for Rational Living, 45 East 65th Street, New York, N.Y. 10021, 1976.

In this self-help article Wolfe offers instructions to women on how to become sexually assertive. She writes that assertiveness training applied to sexuality can provide a means for defining and following one's own sexual tastes, for getting rid of the concept that men are sexual beings and women are not, and for learning to please oneself. The sexually assertive woman's ability to speak up in a direct manner for her own rights and preferences in a way that does not violate the rights of others is distinguished from aggressiveness and nonassertiveness. Wolfe lists some of the negative social messages women receive about sex that make it difficult for them to feel good about themselves and their sexuality. On the basis of her observations, Wolfe suggests that the major psychological blocks to sexual assertiveness are "love-slobbism," guilt, self-deprecation and fear of failure, and anger and hostility. She explains each of these blocks and provides assertive self-messages for combating them. In addition to overcoming these psychological blocks, women need to start defining themselves and redefining their sexuality instead of accepting society's definitions of how they are supposed to be. Specific activities are recommended for accomplishing this — reading to learn about female sexuality, talking to other women about sexual experiences, and discovering one's own body. Presenting assertiveness as learned behavior that requires practice, Wolfe suggests that women pinpoint the behavior they want to change and take a few steps at a time. Initiating sex and relationships is discussed. Learning to say no to sex without guilt is also presented as an important part of sexual assertiveness. Women must come to realize that their desires are not incorrect and should not be afraid of pursuing them. Wolfe states that women must assume responsibility for their own orgasms, although she indicates that the orgasm is not all-important. She gives several suggestions on how more and better orgasms can be achieved by learning about oneself and being assertive. She points out that being sexually assertive does not mean being aggressive in the style of machismo and that sexual equality reflects caring and a willingness to share. Wolfe maintains that being assertive and expressive is being liberated and alive, and that "sex can be a pleasurable and important way of expressing that aliveness."

407.

Women in Transition, Inc. *Women in Transition: A Feminist Handbook on Separation and Divorce.* New York: Charles Scribner's Sons, 1975. 538 pp.

This self-help volume, a resource book for women in transition, begins with a presentation of the purpose, history, and actual services provided by the Philadelphia Women in Transition resource program — a program that offers survival skills and emotional support to women experiencing separation, divorce, or single parenthood. The program is divided into two main areas — emotional support and legal support. The emotional support aspect includes small groups, therapy evaluations and referrals, consultations to agencies in order to promote their sensitivity to the needs of women in transition, a pro se divorce clinic, and outreach in the form of workshops in low- and middle-income communities on women's legal rights and options. Describing how this book came to be written, the authors explain their decision to prepare a national version that would enable individual women throughout the United States to find needed resources and strength and to assist groups wanting to establish programs for women in transition in their areas. The personal experiences of women in transition are recounted throughout the book. Following an introduction that identifies the project, attention is directed to emotional supports. In this chapter focus is on the problems, fears, strengths, and weaknesses of women in transition. The authors discuss the concept of marriage held by women in this culture and the common and different experiences of middle-class and working women after a separation. Identifying pain as one of the primary feelings during the transition period, the authors explore some of the ways women can cope with their pain. They then deal with emotional supports in terms of relationships with friends, family and children, and men. Pointing out that the consciousness-raising group has served as the basis of the women' liberation movement, they present and discuss the small group as an important source of support for a woman in transition. The authors indicate that many women who think they need therapy at this time are able to get the support they require from a women's group. A transcript of a tape made at one of the Philadelphia Women in Transition group meetings is included. The book's third chapter includes mothers' observations of children's reactions to their separations or divorces and how the mothers responded to the problems that developed. The chapter on the law gives women guidance on the legal questions that need to be asked to facilitate movement to a more independent and self-sufficient life. The financial resources chapter helps women deal with the economic realities of separation and divorce, the problems of living on welfare, women's work, sexism at work, educational and financial resources, and insurance. The chapter on life space addresses the issue of where to live. Some of the options a woman in transition has are outlined, and suggestions are provided on how to act on them. The "Taking Care of Ourselves" chapter is designed to give women in transition the information they need to maintain their health, to use medical and mental health services, and to evaluate the care they receive. In the discussion of mental health, information is provided to guide a woman in determining if she needs and wants therapy. The authors present the possible benefits and limitations of therapy, explain what a therapist is, where therapy is done, and how to go about choosing and evaluating a therapist. In the final chapter, the authors describe their own program, encouraging its use as a model for those wanting to develop a similar project. A bibliography is included along with an appendix which provides addresses of the national offices of several organizations working with women in transition as well as a State-by-State listing.

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